

2016

What Works for Successful In-Home Family Therapists Working at Community-Based Agencies

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**WHAT WORKS FOR SUCCESSFUL IN-HOME FAMILY THERAPISTS
WORKING AT COMMUNITY-BASED AGENCIES**

by

Aleyah Yasin

A Dissertation Presented to the
College of Arts, Humanities, & Social Sciences
In Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University

2016

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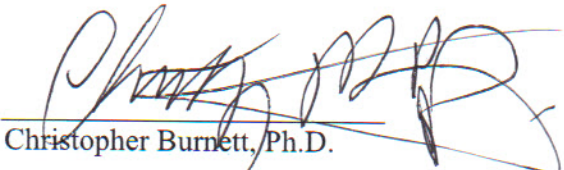
Nova Southeastern University
College of Arts, Humanities, and Social Sciences


This dissertation was submitted by Aleyah Yasin under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

Approved:

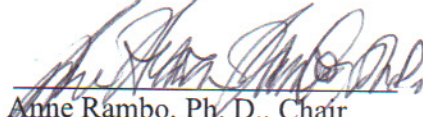
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Acknowledgments

It was a true journey for me to accomplish writing this dissertation within the last two years. In light of the challenges I overcame, I would like to thank several people for helping me through this process. First, I would like to thank God for giving me life, a chance to work through my obstacles. Next, I would like to thank my mother and late father for their united wisdom, strength, love, and imparting of the mantra: I will, I must, I can! To my brother, Ahmaul Yasin, and his wife, Brittany Yasin: Thank you both for the loving encouragement, humor, and love you shared with me throughout my journey.

If not for the combined efforts of my Chair and committee members, I would not have been able to finish this dissertation in the time and manner that I did. Thank you to my Chair, Dr. Anne Rambo, for your constant support and motivation in helping me work through the many challenges I experienced in this process. To my committee members, Dr. Chris Burnett and Dr. Kara Erolin, thank you both for your guidance throughout this journey by helping shape this dissertation. Everyone I have acknowledged here, along with my friends and extended family members, contributed to providing the supportive network that I needed to not only bring this document to life, but complete it as well.

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Abstract

Resiliency is an important characteristic of successful therapists (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Clark, 2009; Hamel & Laraway, 2004; Kuiper, 2012; Protinsky & Coward, 2001; Rosenberg & Pace, 2006; Wolgien & Coady, 1997), especially those in entry-level positions that tend to involve high stress and turnover (Acker, 2004; Clark, 2009; Davis, 2013; Greenson, Guo, Barth, Harley, & Sission, 2009; Grosch & Olsen, 1994; Gupta, Peterson, Lysaght, & Zweck, 2012; Horan, 2002; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Skovolt & Trotter-Mathison, 2011). This study explored the perspectives of six therapists providing in-home services in community based agencies who succeeded and thrived in entry-level positions. The researcher inquired about how the therapists defined and maintained necessary resiliency. The participating therapists were recommended by their agency directors for their exemplary performance; they defined themselves as succeeding and thriving. The researcher used the qualitative research method of phenomenology (Kafle, 2011) to examine the participants' lived experiences. The researcher derived five primary themes from the thematic analysis of the interviews: (1) In-home therapists should enjoy the freedom of their jobs; (2) In-home therapists should schedule their time creatively; (3) In-home therapists should understand the unique needs of their clientele; (4) In-home therapists should practice self-care; and (5) In-home therapists should vary their clientele. These themes represent methods by which the participants manage to become successful in-home therapists and prevent burnout.

CHAPTER I: INTRODUCTION

Home-and-community-based care is not a new phenomenon. In fact, this kind of care dates back centuries to efforts from families and friends in the community to provide supportive care to the disabled and chronically ill (Cluff & Binstock, 2001). During the latter part of the 20th century, a convergence of systemic trends—aging population, pre-existing disabilities, women's increasing participation in the labor force—placed complex and competing demands on what has been a predominately informal system of care (Cluff & Binstock, 2001).

This system of care inevitably influenced professionals within the marriage and family therapy (MFT) field providing in-home and community-based care, prompting them to develop the unique branch of therapy known as community-based family therapy (Cluff & Binstock, 2001). Community-based family therapy is inclusive of therapeutic services that are provided in either private homes or at community-based agencies that receive Medicaid (Boyd-Franklin & Bry, 2000; Christensen, 1995; Cluff & Binstock, 2001; Hamel & Laraway, 2004; Killian, 2013; Negash & Sahin, 2011; Paris, Linville, & Rosen, 2006; Rosenberg & Pace, 2006; Thomas, McCollum, & Snyder, 1999; Trudeau, Russell, Mora, & Schmitz, 2001).

Over the years, in-home and community-based care have become a popular means for families in communities to access therapeutic services despite their socioeconomical circumstances (Christensen, 1995; Cluff & Binstock, 2001). However, community-based family therapists are spread too thin in the process of providing therapeutic services due to the many personal sacrifices it involves and the constant strain it places on their personal lives, detracting them from spending time with their family and friends (Cluff &

Binstock, 2001; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006).

Due to the sizable constraints of organizational structuring and the high-stress work environment of community-based agencies, MFTs and other psychotherapists find themselves struggling to maintain some semblance of balance between their professional and personal lives given the *spillover effect* occurring at the cost of their personal or professional responsibilities (Appel & Appel, 2008; Grosch & Olsen, 1994; Maslach & Leiter, 1997; Negash & Sahin, 2011; Peirce, Thomas, & Sprenkle, 1998; Rosenberg & Pace, 2006). To compensate for these difficulties, community-based agency clinicians rely on multi-tasking and compartmentalizing skills to aid them in managing ever-changing agency policies, job requirements, large caseloads, and significant paperwork (Maslach & Leiter, 1998; Negash & Sahin, 2011; Rosenberg & Pace, 2006). The pressures related to time, money, multiple-role demands, and high workplace expectations cause therapists to develop stress-related problems that decrease their performance levels at work, eventually resulting in burnout (Appel & Appel, 2008; Grosch & Olsen, 1994; Maslach & Leiter, 1998; Negash & Sahin, 2011; Peirce, Thomas, & Sprenkle, 1998; Rosenberg & Pace, 2006; Skovholt & Trotter-Mathison, 2011). Given that their performance and coping skills are under constant scrutiny at community-based agencies, MFTs pay a high price in trying to disguise these feelings (Appel & Appel, 2008; Grosch & Olsen, 1994; Maslach & Leiter, 1998; Negash & Sahin, 2011; Peirce, Thomas, & Sprenkle, 1998; Rosenberg & Pace, 2006).

Due to the spillover of their professional and personal responsibilities, community based family therapists resort to coping mechanisms such as 1) seeking formal training,

2) gaining more clinical experience, 3) allowing themselves to be human, 4) developing resiliency, and 5) forming a resilient attitude to help them establish a sense of balance and maintain the unique passion that drives them forward in working through their obstacles and challenges. The purpose of this paper is to explore what works for successful in-home family therapists working in community-based agencies. I will utilize the qualitative method of phenomenology to explore the lived experiences of MFTs who are successfully providing in-home services in community-based agencies (Kafle, 2011).

Exploring Resiliency in Community-Based Agencies

My passion for exploring therapist resiliency in community-based agencies originated when I was an MFT intern serving as an in-home counselor in a reputable, privately owned, community-based agency in Fort Lauderdale, Florida. I was a Canadian international student who was eager and excited about the opportunity to use my formal education in marriage and family therapy in the context of a community-based agency. My position involved a tremendous amount of driving to clients' homes, schools, and agencies, but the driving also helped me decompress between appointments. I believed that my Guyanese-Indian ethnic upbringing and my Islamic faith aided me in understanding my clients' perspectives and helping me build a deeper rapport with them while enhancing the therapeutic experience. The experience became one of appreciation and hope as we worked together on the clients' therapeutic goals.

However, as much as I valued creating therapeutic experiences, it came at a heavy cost, as I spent so much time focusing on the professional aspects of my life I neglected the personal and social parts. I spent much of my time driving, scheduling and rescheduling appointments, managing paperwork, attending meetings, and receiving

supervision. I found myself struggling to meet the demands of the job while simultaneously putting off my responsibilities in my personal life involving family and friends. After long days at work, I would come home expecting family members to give me opportunities to vent about my day, but I was repeatedly disappointed when instead they expressed their disappointment about the lack of time I was spending with them due to my working all the time. They could not understand why I was spending such an inordinate amount of time at work. Frustrated and concerned about the direction of my life, I began to wonder if I was doing the right thing by working as an outpatient clinician. At times I even considered leaving the agency altogether.

The bustling atmosphere of my work environment was intimidating. I felt embarrassed that I, a Ph.D. graduate student, was struggling so early in my career to manage my caseload and workload. To cope, I compartmentalized my insecurities and isolated myself at work, always wondering if I was the only one experiencing this. Eventually, I learned that I was not alone. Observing other therapists abruptly resign and leave because of job stress, low pay, and inadequate social lives led me to realize that repeated compartmentalization was no longer a solution.

Hearing friends and coworkers share their stories of frustration normalized my experience of feeling spread too thin; it helped me realize that I was not alone in this situation. By engaging in conversations with peers and opening up about some of my experiences, I was able to release some of my pent-up frustrations while simultaneously learning from their experiences. My peers and I were able to give mutually beneficial feedback on a variety of issues such as managing caseloads and paperwork.

Of all the conversations I had, the one I most often reflect on was with a co-worker at our community agency about a bad day he was having. He shared with me that earlier that day, he had met his adolescent client for their usual therapy session at the client's school. My co-worker had played basketball with the client, as he often did, to create a therapeutic bond. At some point during the game, he said the client leaned forward and slapped his face. Nervously, he admitted that he responded without thinking by slapping the adolescent boy's face. My co-worker said the boy did not return the strike, but my co-worker ended the session early. Concerned, I advised my co-worker to talk to our supervisor and be honest about what happened.

This incident made me think more deeply about the nature of therapy in the context of working in community-based agency settings. As clinicians, we are trained and educated to view our clients from a therapeutic perspective. Whether we use cognitive behavioral, solution-focused, narrative, or reality therapy, the end result is the same: We maintain therapeutic rapport by implementing our ethical and professional opinions in the moment to help our clients attain their treatment goals. Because of this immediacy, we will come face-to-face with the fact that we are human first, and we will make mistakes.

Even though my co-worker is a very good clinician, he was momentarily overwhelmed by the pressures of his professional and personal responsibilities. He was exhausted and possibly burnt out. Even though his reaction to his client's behavior was a completely human one, the incident tarnished his credibility and reputation as a clinician.

This moment stood out as definite turning point for my friend and served as a big wake-up call for me that I, too, could snap. I pondered this question: How are masters-

level therapists working at community-based agencies supposed to balance the professional and personal aspects of our lives without snapping or burning out?

Supported by the research, the answer to my question related to resiliency functioning as a means of maintaining balance in the personal and professional lives of therapists (Clark, 2009; Maslach & Leiter, 1997; Skovholt & Trotter-Mathison, 2011). Hopefully, therapists are able to tap into memories and other aspects of their lives that help them join with, validate, empower, and empathize with clients while maintaining their personal passions and energies (Aponte, 1991; Aponte & Winter, 2000; Clark, 2009; McConaughy, 1987). Resiliency heightens therapists' sense of self, allowing them to gauge their own composure. During tense sessions with clients, resilient therapists will not only notice what might be stirring within their clients but also notice what might be stirring within themselves (Aponte, 1991; Clark, 2009; Grosch & Olsen, 1994; Paris, Linville, & Rosen, 2006; Piercy, Thomas, & Sprinkle, 1998; Wolgast & Coady, 1997). These therapists are able to connect, gauge, and understand themselves better by maintaining a level of self-respect that allows them to identify what they need to relieve themselves of the stress. Therapists should involve themselves in coping mechanisms such as self-care, supervision, personal therapy, and fun activities (Aponte, 1991; Aponte & Carlsen, 2009; Clark, 2009; Leiter, Maslach, & Schaufeli, 2001; Lutz & Irizarry, 2009; Maslach & Leiter, 1997; Negash & Sahin, 2011; Paris, Linville, & Rosen, 2006; Skovholt & Trotter-Mathison, 2011). When therapists do this, they take steps in remembering who they are in order to maintain professional and personal balance (Aponte, 1991; Aponte & Carlsen, 2009; Clark, 2009; Leiter, Maslach, & Schaufeli, 2001; Lutz & Irizarry, 2009;

Maslach & Leiter, 1997; Negash & Sahin, 2011; Paris, Linville, & Rosen, 2006; Skovholt & Trotter-Mathison, 2011).

Definition of Key Concepts

Community-Based Family Therapy

Community-based family therapy is heavily rooted in the world of home-and-community-based care (Boyd-Franklin & Bry, 2000; Christensen, 1995; Cluff & Binstock, 2001; Hamel & Laraway, 2004; Killian, 2013; Negash & Sahin, 2011; Paris, Linville, & Rosen, 2006; Rosenberg & Pace, 2006; Thomas, McCollum, & Snyder, 1999; Trudeau, Russell, Mora, & Schmitz, 2001). It is used as a catch-all phrase to refer to therapeutic services provided in non-institutionalized settings including private homes and community-based agencies receiving Medicaid. Home-and-community-based care has become the common means by which families receive therapy in their communities (Christensen, 1995; Cluff & Binstock, 2001).

Community-Based Agencies

These facilities provide mental health services and other forms of care to diverse families and individuals in the community (Cluff & Binstock, 2001; Maslach, 1982; Maslach & Leiter, 1997).

Burnout

According to Freudenberger (2011), burnout refers to being in a state of fatigue and frustration that is brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward. He elaborates that burnout has two important aspects: (1) It is an erosion of the spirit and the soul that leads to a loss of faith in the enterprise of helping, and (2) It describes how the typical working dynamic within the

helping professions causes psychotherapists to replace high ideals and commitment with disillusionment and cynicism (Grosch & Olsen, 1994).

Self of the Therapist

This term refers to therapists' utilization of both personal material and professional skills in session (Aponte, 1991; Clark, 2009; Grosch & Olsen, 1994; Paris, Linville, & Rosen, 2006; Piercy, Thomas, & Sprinkle, 1998; Wolgast & Coady, 1997).

Resiliency

Resiliency refers to therapists' practice of maintaining balance in both the personal and professional aspects of their lives (Clark, 2009; Maslach & Leiter, 1997; Skovholt & Trotter-Mathison, 2011)

Resilient therapists. Characterized as being older, more experienced, and able to create a positive work environment; resilient therapists are able to manage their work stressors and nurture themselves in ways that allow them to establish clear boundaries and rely on their sense of self to maintain enriching peer relationships and a sense of proactivity in resolving personal issues (Clark, 2009; Rosenberg & Pace, 2006).

CHAPTER II: LITERATURE REVIEW

Due to the high demand for mental health care in North America, community-based family therapists are experiencing burnout at an alarming rate (Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff & Binstock, 2001; Grosch & Olsen, 1994; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Stinchfield, 2004). It is “estimated that approximately 10-15% of practicing mental health professionals will succumb to burnout during the course of their careers” (Clark, 2009, p. 231). As such, marriage and family therapists (MFTs), in addition to other psychotherapists, find themselves being spread too thin by sizable constraints placed on them in the stressful organizational structures of community-based agencies (Maslach & Leiter, 1997; Nagash & Sabin, 2011; Rosenberg & Pace, 2006). Throughout this study, I will refer to MFTs as *therapists* and *family therapists*.

Community-Based Family Therapy

Community-based family therapy is heavily rooted in the world of home-and-community-based care (Boyd-Franklin & Bry, 2000; Christensen, 1995; Cluff & Binstock, 2001; Hamel & Laraway, 2004; Killian, 2013; Negash & Sahin, 2011; Paris, Linville, & Rosen, 2006; Rosenberg & Pace, 2006; Thomas, McCollum, & Snyder, 1999; Trudeau, Russell, Mora, & Schmitz, 2001). Viewed as a catch-all phrase for therapeutic services provided in non-institutionalized settings like private homes and community-based agency facilities receiving Medicaid, home-and-community-based care has become the common form of therapy for families in the communities (Cluff & Binstock, 2001; Christensen, 1995). Referred to frequently in the literature, the term *community-based family therapy* is often used interchangeably with *in-home family therapy* and *home-*

based family therapy (Boyd-Franklin & Bry, 2000; Christensen, 1995; Cluff & Binstock, 2001; Hamel & Laraway, 2004; Killian, 2013; Negash & Sahin, 2011; Paris et al., 2006; Rosenberg & Pace, 2006; Thomas et al., 1999; Trudeau et al., 2001).

Home-based services function as an effective strategy for engaging clients in treatment who would otherwise be unable or unwilling to attend clinic appointments regularly (Christensen, 1995). Researchers view home-based family therapy as a tool for gathering information and making assessments (Christensen, 1995; Hamel & Laraway, 2004; Paris et al., 2006; Rosenberg & Pace, 2006; Thomas et al., 1999; Walter & Petr, 2006). This form of therapy provides an avenue for therapists to directly address the real problems systemically connected to family dynamics (Berg, 1994; Berg & Dolan, 2001; Christensen, 1995). When they are grounded in the present moment with their clients, therapists are able to see the client family's problems as they occur in their natural setting. They can then utilize the clients' living environment, values, culture, and investment in the treatment process as part of the treatment (Christensen, 1995). Since therapy takes place in clients' homes, clients tend to be less defensive and derive comfort from the familiarity of their surroundings (Christensen, 1995). In-home community based therapists are better able to listen to their clients' current circumstances and shape the therapeutic experience to fit their needs (Christensen, 1995).

The purpose of this study is to explore what works for successful in-home family therapists working at community based agencies. To achieve this, I will deconstruct the concept of community-based family therapy in the next section, in order to investigate the following: (1) its origins (Christensen, 1995; Cluff & Binstock, 2001); (2) its advantages and challenges (Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff &

Binstock, 2001; Grosch & Olsen, 1994; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Stinchfield, 2004; Walter & Petr, 2006); (3) the business dynamics involved (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009); and (4) a present day reality check (Clark, 2009; Grosch & Olsen, 1994; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Skovolt & Trotter-Mathison, 2011).

Origins of Community-Based Family Therapy

In 1980, the path for home-based family therapy was paved further when Congress passed the Public Law 96272, which led the states of California, Colorado, Maryland, New York, Pennsylvania, and Washington to shift the direction of federal funding from placement in foster care to prevention and family reunification (Christensen, 1995). These states' efforts were focused on keeping children in their natural homes by promoting alternative in-home programs instead of removing children from their homes and placing them in group homes, foster homes, and general or psychiatric hospitals (Christensen, 1995). The in-home programs were focused on the family preservation model of helping all members of the family implement change (Christensen, 1995). Hospitals and nursing homes were viewed as passive settings in which care was given. Contrastingly, in-home treatment was seen as an integration of parenting, acculturation, love, unity, and a blending of the past with the present (Cluff & Binstock, 2001). As such, in-home treatment has come to be viewed as more conducive to the therapeutic process, given that the home functions as a safe haven from the harshness of the outside world while shedding insight as to the clients' culture and family background (Cluff & Binstock, 2001).

Advantages and Challenges of Community-Based Family Therapy

Viewed as an increasingly effective and popular service in communities; home-based family therapy presents both advantages and challenges (Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff & Binstock, 2001; Grosch & Olsen, 1994; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Stinchfield, 2004; Walter & Petr, 2006). The advantages of this form of therapy include the therapist being present with clients, generating a big picture perspective of the family's contextual problem. Furthermore, it functions as a cost effective form of treatment. The challenges associated with community-based family therapy include client resistance, anger from clients, family conflicts, and multiproblem families (Boyd-Franklin & Bry, 2000; Stinchfield, 2004; Thomas, 1999), as explained below.

Being present with clients in their homes allows therapists to experience clients' home lives (Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff & Binstock, 2001; Grosch & Olsen, 1994; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Stinchfield, 2004; Walter & Petr, 2006). Observing families' verbal and non-verbal communication in vivo provides a clearer picture of what is really occurring within the families (Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff & Binstock, 2001; Grosch & Olsen, 1994; Hamel & Laraway, 2004; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Stinchfield, 2004; Walter & Petr, 2006). Direct observation of families in their natural settings guides therapists in adjusting their therapeutic language that it becomes metaphorically meaningful to the client (Christensen, 1995; Walter & Petr, 2006). As a result, the therapists are able to work with at risk families suffering from severe emotional, mental, and behavioral problems (Boyd-Franklin & Bry, 2000; Stinchfield, 2004; Walter & Petr, 2006).

Once therapists establish trust with their clients in the home environment, they have the opportunity to interact with everyone involved in the clients' families (Boyd-Franklin & Bry, 2000). Because the concept of family has broadened to include blood relatives as well as non-blood relatives like extended family members, friends, and other supports, these individuals can be involved in the therapeutic process once the client provides consent (Boyd-Franklin & Bry, 2000). This allows therapists to generate a big picture perspective of clients' family dynamics in relation to their living circumstances, which may include poverty, substandard housing, drugs, crime, overcrowding, and unsafe neighborhood; cultural characteristics, like food and music; and family rules in practice (Boyd-Franklin & Bry, 2000). In-home therapists are able to use their own guiding principles and manners in the session as a means joining and building rapport with clients (Boyd-Franklin & Bry, 2000). This allows them to engage with families and encourage them to attend sessions (Walter & Petr, 2006).

Home-based family therapy is considered a cost effective means of receiving therapy through Medicaid (2006). An example of this can be seen in Kansas, where in-home family therapy programs are associated with the least expensive option among available Medicaid treatments, which can leave clients and their families with “. . . total medical costs of \$1,622 for the 30 months after in-home therapy” (Walter & Petr, 2006, p. 4). According to Walter and Petr (2006), “This figure is 85% less than the average cost for those who received in-office family therapy and 90% less than those who received no family therapy” (p. 4). Therefore, the cost effectiveness of in-home therapy allows for therapeutic services to be accessible to families despite their socioeconomically circumstances (Walter & Petr, 2006).

Despite the many advantages of in-home therapy, therapists can experience many challenges in the homes, including resistance, angry clients, family conflicts, and multiproblem families (Boyd-Franklin & Bry, 2000; Thomas, 1999; Stinchfeild, 2004). Because clients are often referred to therapy by people in schools, social welfare, agencies, police departments, and the courts, in-home family therapists are often met with resistance, anger, and resentment from clients who view them as representatives of the system that initiated services. Many clients see community-based therapy as an intrusion into their lives (Boyd-Franklin & Bry, 2000).

Clients express resistance in a number of ways, ranging from not showing up for the first appointment to inconsistently attending appointments (Boyd-Franklin & Bry, 2000). As Boyd-Franklin and Bry (2000) state:

It is important that family therapists be trained to expect initial ‘resistance’ and anger on the part of some family members at being forced to participate in treatment and that they be prepared to work harder to engage these family members in the treatment process. (p. 43)

In line with this, it is recommended that family therapists be persistent with clients to counter their resistance, build and re-build rapport, and flexibly accommodate the family’s desired direction and pace of therapy (Boyd-Franklin & Bry, 2000).

Clients may direct anger at therapists as a means of venting frustration over being persecuted, judged, and disappointed by the same system that is trying to provide aid (Boyd-Franklin & Bry, 2000). Therapists are encouraged to acknowledge and validate clients’ initial distrust by inquiring about their experience and feelings about dealing with the system (Boyd-Franklin & Bry, 2000). As Boyd-Franklin and Bry (2000) put it, “If

family therapists feel anger coming on and are afraid of expressing this anger or insulting clients—a very normal reaction to an angry confrontation—they should respectfully tell the client that they will return at a later time” (p. 44).

Therapists should seek advice from supervisors, administrators, and more experienced family therapists to process their anger without interfering with the therapeutic relationship (Boyd-Franklin & Bry, 2000). In situations of continuous angry confrontations with particular clients or family members, it is recommended that therapists seek co-facilitators to address the issue using a team approach (Boyd-Franklin & Bry, 2000). Furthermore, agency directors and supervisors should provide creative and supportive learning environments for family therapists to broaden their therapeutic skills for working with this particular population (Boyd-Franklin & Bry, 2000).

Clients who are recommended for home-based therapy often have multiple, systemically intertwined problems occurring simultaneously (Boyd-Franklin & Bry, 2000). Most of the individuals seeking therapy have children and adolescents who have been diagnosed with serious emotional, behavioral, and mental health disorders and have received therapeutic services from other systems that struggled to identify their needs and implement services that meet their needs (Stinchfeild, 2004). When office-based services are not effective in treating families’ clinical issues, the home is believed to be the optimal therapy setting (Stinchfeild, 2004). Since therapists are regularly exposed to families who were not helped by office-based services, their reaction of feeling overwhelmed, viewing clients’ problems as hopeless, and assuming that the families cannot be empowered to change is understandable (Boyd-Franklin & Bry, 2000). This leads therapists to become so stressed that they bring in outside agencies and services in

attempts to fix clients' multisystemic problems (Boyd-Franklin, & Bry, 2000). However, instead of fixing the situation, this only leads to a multi-systemic nightmare, in which many agencies collaboratively try to help the client and family but instead end up giving different, often conflicting, solutions (Boyd-Franklin & Bry, 2000).

Business Dynamics of Community-Based Agencies

Like most companies, community-based agencies function as business (Aarons et al., 2009). Aarons, Wells, Zagursky, Fettes, and Palinkas (2009) explored the business dynamics of community-based agencies and identified the factors most likely to affect the implementation of evidence-based practices in public sector mental health settings. Examining multiple stakeholder groups ranging from policymakers to funders to consumers, they found that it takes 15 to 20 years for effective treatment practices to become common practice. The researchers stressed that time combined with unnecessary financial costs has serious implications in public sector mental health systems that serve vulnerable families (Aarons et al., 2009). As difficult as it is to gain access to these services, it is critical that mental health agencies utilize the most effective services for the agency, provider, and consumer (Aarons et al., 2009).

Aarons et al. (2009) raised the question of what is meant by *evidence* as it relates to stakeholder perspectives across system levels. Evidence presented to stakeholders are reflective of the generalization of research that dilutes the perspectives of what are considered to be effective treatment interventions (Aarons et al., 2009). The researchers recommend that closer attention be paid to diverse perspectives regarding intervention and treatment efficiency pertaining to policy, management, clinical, and consumer (Aarons, 2009). This way the multiple types of evidence used in making policy

decisions—which are derived from research, background knowledge and ideas, political and economic factors, differences in agenda, and design development—can be explored, allowing more attention to be directed at engaging stakeholders in identifying potential barriers to service delivery (Aarons, 2009). Supportive resources can be incorporated and changes in leadership can be made through organizational trainings and the delivery of incentives. This will provide support to all stakeholders, generating an overall attitude of organizational change that is necessary for organizational adaptation (Aarons, 2009).

Aaron et al. (2009) also stress that evidence-based programs (EBP) are more popular than other forms of therapy mainly due to the research that supports it. However, the validity of EBP is still challenged because of the multi-layered framework that exists including program managers; agency directors; and local, state, and federal policymakers (Aarons, 2009). Along with the challenge of satisfying diverse stakeholders come requirements for empirical examination of programs to determine their viability (Aarons, 2009). Several EBP models were designed to be dispensed in community-based agencies. Some of the most popular ones include Functional Family Therapy (FFT) (Sexton & Alexander, 2004), Multisystemic Therapy (MST) (Multisystemic Therapy), and Multidimensional Systemic Theory (MDST) (Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005).

Functional Family Therapy (FFT) is a well-established, evidence-based family therapy intervention geared towards addressing violent, criminal, school-based, and conduct problems among youth and their families (Sexton & Alexander, 2004). According to Sexton and Alexander (2004), “The results of published studies suggest that FFT is effective in reducing recidivism between 26% and 73%

with status offending, moderate, and seriously delinquent youth as compared to both no treatment and juvenile court probation services” (p. 14). The FFT service delivery system provides families with access to therapists, community-based agencies and particular tools that offer comprehensive treatment for youth in the mental health, juvenile justice, and welfare systems (Sexton & Alexander, 2004). Considered a low-cost form of treatment, FFT is associated with positive outcomes, and the cost-to-benefit ratio is high (Sexton & Alexander, 2004). Because FFT is a family-based and strength-based model, it is effective in highlighting the relational and systemic components involved in structuring an understanding developed in the moment-by-moment clinical strategies in managing the complex families (Sexton & Alexander, 2004).

Multisystemic Therapy (MST) is another evidence-based family therapy approach used as an intensive family-based and community-based treatment for addressing anti-social behavior among juvenile offenders (Multisystemic Therapy, n.d.). Working with delinquencies in young people’s key systems, including their families, peer networks, schools, and neighborhoods, MST promotes behavioral changes in the young people’s natural environments. The model uses the strengths of each system to foster positive change (Multisystemic Therapy, n.d.). “Studies with violent and chronic juvenile offenders showed that MST reduced long-term rates of rearrest by 25 percent to 70 percent compared with control groups” (Multisystemic Therapy, n.d., *Research* section, para. 2). The goals of MST are to lower rates of youth criminal activity, reduce anti-social behaviors such as drug abuse, and decrease rates of incarceration and out-of-home placement

(Multisystemic Therapy, n.d.). To do this, MST therapists focus on collaborating with and empowering parents by strengthening their natural support systems, such as their families, friends, neighbors, and members of their spiritual or religious communities in order to improve their ability to deal with their children (Multisystemic Therapy, n.d.).

Lastly, Multidimensional Family Therapy (MDFT) is an evidence-based, family-based outpatient approach that focuses addressing adolescent substance abuse and related mental health and behavioral problems (Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005). The MDFT approach is designed to help youth develop coping skills and problem solving skills to aid them in better decision making and improved interpersonal functioning with their families. This is believed to help prevent substance abuse and other related problems (Liddle et al., 2005). Multidimensional Family Therapy (MDFT) is a manualized approach that:

. . . uses research-derived knowledge about risk and protective factors for adolescent drug and related problems as the basis for assessment and intervention in four domains: (1) the adolescent as an individual and as a member of a family and peer group; (2) the parent, both as an individual adult and in his or her role as mother or father; (3) the family environment and the family relationships, as evidenced by family transactional patterns; (4) extrafamilial sources of positive and negative influence. (p. 128).

Because MDFT was developed and tested as a systemic form of treatment rather than a one-size-fits-all approach, it has received the highest rating among available research-based adolescent drug abuse intervention programs (Liddle et al., 2005).

Reality Check of Community-Based Family Therapy

Community based family therapists face daily reality checks that cause them to feel worn out and burnt out (Clark, 2009; Grosch & Olsen, 1994; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Skovolt & Trotter-Mathison, 2011). Inevitably, the community-based system of care requires the therapists who work within it to make personal sacrifices that detract from their time with family and friends (Cluff & Binstock, 2001; Maslach, 1982; Maslach & Leiter, 1997). In addition to providing in-home family therapy, the job description for family therapists also includes being familiar with city resources and being available 24 hours a day, seven days a week for on-call crisis interventions and collaborations with school staff, physicians, social workers, in-patient staff, residential staff, case workers, and representatives from the courts (Stinchfield, 2004).

Therapists deal with pressure stemming from policy issues and agency structurings that precipitate increased caseloads and corresponding increases in paperwork, tighter completion deadlines, and smaller salaries (Negash & Sahin, 2011). Therapists must deal with these factors while trying to navigate other issues such as high client no-show rates, hiring freezes, pay freezes, and cutbacks. (Grosch & Olsen, 1994; Maslach & Leiter, 1998). The constant pressures related to time and money, along with multiple-role demands and high workplace expectations, cause therapists to experience

stress-related problems that negatively affect their work performance and job satisfaction (Shovholt & Trotter-Mathison, 2011).

Current economic factors like inflation and unemployment force therapists to rely heavily on multi-tasking skills in order to practice therapy in community-based agencies (Maslach & Leiter, 1998; Negash & Sahin, 2011; Rosenberg & Pace, 2006). Clinicians maintain their caseloads by feverishly scheduling and re-scheduling sessions at locations that are convenient for the clients, such as community organizations, schools, homes, hospitals, and sometimes a combination of one or more of these settings (Rosenburg & Pace, 2006). Additionally, therapists are often unprepared for the lack of appreciation they receive from clients and agencies for the efforts they make in cementing therapeutic relationships; they quickly find themselves feeling stressed and pressured to produce immediate results (Grosch & Olsen, 1994). Therapists face the unrealistic expectation of curing their clients in spite of their heavy workloads and one-way relationships they have with clients (Grosch & Olsen, 1994). To succeed, therapists resort to embracing quick fixes that function as medications to treat infections of unhappiness (Grosch & Olsen, 1994). Often forced to work without critical feedback or a sense of perceived success, therapists find themselves feeling overwhelmed and drained (Grosh & Olsen, 1994; Kelloway & Day, 2005).

Stress

The National Institute for Occupational Safety and Health (NIOSH) has identified occupational stress as one of the leading causes of workplace deaths (Kelloway & Day, 2005). According to Kelloway and Day (2005), the lingering reality of occupational stress has put a spotlight on the need for mental health facilities to develop healthy

workplace practices. Healthy workplaces are defined as those that are not only absent of job stressors but also have organizational resources available to help employees handle their jobs and better manage their stress (Aarons et al., 2009; Kelloway & Day, 2005). Kelloway et al. (2005) defines a healthy workplace as one that embraced a holistic approach, including both psychosocial and physical factors known to contribute to employee health and wellbeing. In light of this, healthy workplaces include factors such as a strong organizational culture—which includes support, respect, and fairness—employee involvement, employee development, and work relationships (Kelloway & Day, 2005).

There are two ways in which work affects employees' mental health (Aarons et al., 2009; Horan, 2002; Kelloway & Day, 2005): (1) it affects the psychological, physiological, and behavioral aspects of employees' lives, and (2) it functions as a source of resourceful methods that buffer the effects of non-work stressors in employees' personal and social lives (Horan, 2002; Kelloway & Day, 2005). The American Psychological Association (APA) defines a psychologically healthy workplace as one that promotes and incorporates healthy activities; offers employee assistance programs; has flexible benefits and working conditions; treats employees fairly; and offers programs for employee development, health, safety, and work stress prevention (Kelloway & Day, 2005).

Kelloway and Day (2005) report, "According to most stress models, potential stressors are the objective elements in the environment that may create stress" (p. 224). Perceived stress occurs when individuals have personal experiences that match their preconceived perceptions of job stressors (Kelloway & Day, 2005). Negatively perceived

stress creates strain that reveals itself in indirect ways, potentially reaking psychological, physical, and behavioral havoc. Because the strain is avoidable and that not all stressors affect people in the same way, individual resources and coping styles can create balance (Kelloway & Day, 2005). These resources and coping styles—or lack thereof—can either alleviate or exacerbate negative outcomes (Aarons et al., 2009; Kelloway & Day, 2005).

According to Kelloway and Day (2005), the most common sources of work stress can be narrowed down into the following categories: (1) workload and pace, (2) role stressors, (3) career concerns, (4) work scheduling, (5) interpersonal relationships, and (6) job content and control. Regarding workload and pace, research has identified general concerns about the number of hours required of employees, such as trainees and interns, who are required to work excessively long hours during the course of their training (Kelloway & Day, 2005). Role stressors emerge when the environment affects an employee's ability to fulfill role expectations because of role ambiguity or conflicting demands from two or more sources (Bateson, 1991; Kelloway & Day, 2005). Career concerns relate to such things as job insecurity, fear of job obsolescence, and under and over promotion (Kelloway & Day, 2005).

Work scheduling issues revolve around employees' having to work schedules that cause them to neglect their health, their families, and social aspects of their own personal lives. Furthermore, interpersonal relationships in the workplace can function as stressors and may be related to a lack of supervision, the absence of co-worker support, and even the presence of violence or aggression (Kelloway & Day, 2005). Finally, job control functions as an important predictor of psychosocial health and work related attitudes and behaviors. Kelloway and Day (2005) found a coorelation between role overload and

assessments of both work specific attitudes and mental health that were connected to the issues of workload and pace. Attention must be given to the number of hours employees—especially interns and trainees—are required to work during training and the regular course of their jobs (Kelloway & Day, 2005).

Effective stress intervention programs are urgently needed in work environments (Horan, 2002). At work, “4 out of 10 employees (40%) feel their jobs are ‘very’ or ‘extremely stressful’ with job satisfaction at its lowest in 21 years” (Horan, 2002, p. 3). Furthermore, “11 million workers reported health endangering levels of ‘mental stress at the workplace’” (Horan, 2002, p. 3). Regardless of the cause, stress imposes enormous, far reaching strain on workers’ wellbeing and corporate profitability (Horan, 2002). As Horan (2002) points out:

Workplace stress hits the employers’ bottom line for approximately \$20 billion annually in absenteeism, tardiness, burnout, lower productivity, high turnover, worker compensation, and rising healthcare insurance costs with an estimated one million employees absent on an average work days because of stress and stress related problems . . . (p. 4)

As these statistics suggest, stress associated with the work environment combined with the job requirements established by in-home community based agencies’ policies and procedures ultimately lead to therapist burnout (Clark, 2009; Grosch & Olsen, 1994; Horan, 2002; Maslach & Leiter, 1997; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Skovolt & Trotter-Mathison, 2011).

To understand burnout, it is helpful to consider the metaphor of a burning candle (Lauderdale, 1982; Burning the candle at both ends, 1994). People may choose how the

candle will be burned: rapidly with both ends ablaze or slowly with a dim, flickering flame (Burning the candle at both ends, 1994; Lauderdale, 1982). One may also look at burnout like the flaming fire of life being extinguished, leaving behind only unfulfilled expectations (Burning the candle at both ends, 1994; Lauderdale, 1982). Time is fleeting and opportunities come and go, leaving us in a constant state of trying to make sense of the world and the organizations in which we function (Lauderdale, 1982). In these circumstances, burnout is likely to occur as a result of the impact our choices have not only on our lives, but on the lives of others as well (Aponte & Carlsen, 2009; Burning the candle at both ends, 1994; Buscaglia, 1978; Krueger & Powell, 1990; Lauderdale, 1982). Inevitably, the candle will burn out; however, how the candle burns depends on the choices we make (Burning the candle at both ends, 1994; Lauderdale, 1982).

Burnout

Herbert J. Freudenberger first used the term *burnout* in the 1960s to describe drug abusers who suffered a slow erosion of motivation and competence that led them to lose interest in everything except their drugs (Grosch & Olsen, 1994; Skovholt & Mathison, 2011). To explain the loss of motivation experienced by the practitioners who worked with these addicted clients, Freudenberger (as cited in Grosch & Olsen, 1994) labeled burnout a “. . . state of fatigue and frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward” (p. 4). According to Freudenberger (as cited in Grosch & Olsen, 1994), burnout has two important components: (1) it is an erosion of the spirit and the soul that leads to a loss of faith in the enterprise of helping, and (2) it describes how the dynamics within the helping

professions lead psychotherapists to replace high ideals and commitment with disillusionment and cynicism.

Burnout Symptom Breakdown

Burnout symptomology results from a multitude of simultaneously occurring events that affect therapists physically, psychologically, behaviorally, and spiritually (Grosch & Olsen, 1994; Killian, 2008; Lauderdale, 1982; Leiter et al., 2001; Maslach, 1982; Maslach & Leiter, 1997; Rosenberg & Pace, 2006). The physical manifestations of burnout include chronic fatigue, gastrointestinal problems, insomnia, headaches, muscle tension, backaches, lack of energy, and hypertension (Grosch & Olsen, 1994; Killian, 2008; Lauderdale, 1982; Rosenberg & Pace, 2006). The behavioral symptoms include “coming to work late, working long hours but accomplishing little, loss of enthusiasm, quick frustration, anger, boredom, increasing rigidity, and difficulty making decisions” (Grosch & Olsen, 1994, p. 5). The emotional and psychological indicators of burnout are “feelings of hopelessness, futility and despair, boredom and cynicism, anxiety, withdrawal, irritability, loss of morale, feelings of isolation, and depression and suicidal ideation” (Rosenberg & Pace, 2006, p. 87). The outcome of burnout leaves individuals with nothing left to give (Killian, 2008; Maslach, 1982).

According to Killian (2008), stress induced fatigue is a symptom of burnout that causes individuals to become forgetful because they have so much to keep track of that it becomes impossible to remember it all. A sense of tunnel vision or disconnection can also occur, causing therapists to lose their sense of time because of their preoccupation with stressful situations on the job (Killian, 2008). Therapists’ thoughts about their work

can follow them home; this can result in panic attacks, agitation, anxiety, sleeplessness, sexual difficulties, and indispensable g of the events of the work day (Killian, 2008).

Burnout symptoms affect people at many levels and can lead them to feel trapped and out of control (Lauderdale, 1982). If these feelings escalate, people may come to embrace the phenomenon of pluralistic ignorance, believing that they are unique and alone in their experience of fading dedication and commitment to work (Lauderdale, 1982). When this happens to therapists, it further erodes their chances of feeling successful in their careers (Maslach, 1982; Maslach & Leiter, 1997).

The Process of Burnout

Burnout exists on a continuum that allows it to be viewed as a developmental process with levels of symptoms that occur at different points in practitioners' lives (Rosenberg & Pace, 2006; ten Brummelhuis, Ter Hueven, Bakker, & Peper, 2011). Lauderdale (1982) and Maslach (1982) explain this further by expanding on the gradual stages of burnout.

According to Lauderdale (1982), burnout does not occur suddenly, but rather comes on gradually in three stages: (1) confusion, (2) frustration, and (3) despair. In the first stage, confusion, people occasionally feel anxious because of poor health maintenance that may cause other health related issues. Symptoms range from headaches and tension to sleeplessness and lack of energy. In the second stage, frustration, people experience intense levels of frustration and anger. They may feel puzzled, confused, cheated, deceived, and robbed of something. These feelings are accompanied by tension-related issues such as headaches and backaches. Finally, in the third stage of despair, individuals feel inadequate, like their efforts have no meaning or value. They become

apathetic, withdrawn, and filled with feelings of despair. It is not uncommon to feel used by others in this stage of burnout (Lauderdale, 1982).

Maslach (1982) identifies three core dimensions of burnout: (1) exhaustion, (2) depersonalization, and (3) reduction of personal accomplishment (Leiter et al., 2001). The hallmark quality of burnout, exhaustion is the most obvious reported manifestation of this problem. Exhaustion is an attempt to distance oneself emotionally and cognitively from one's work as a means of coping with the work overload (Killian, 2008; Leiter et al., 2001). Exhaustion depletes individuals' emotional resources as a result of dealing with a lack of job resources and an absence of feedback or positive rewards, creating overwhelming frustration (Killian, 2008; Leiter et al., 2001). Long hours, high expectations, and exposure to sensitive information leave therapists feeling emotionally and physically exhausted and depleted (Killian, 2008; Skovholt & Trotter-Mathison, 2011). Therapists trapped in these dynamics become further stuck and angry about their circumstances (Maslach, 1982; Maslach & Leiter, 1997).

Therapists Experiencing Burnout

Therapists who are experiencing burnout may find themselves at risk of developing weak and ineffective therapeutic relationships with their clients (Skovholt & Trotter-Mathison, 2011). They may find it challenging to join with clients and strengthen therapeutic relationships when they are emotionally exhausted. With fragile emotional strength, they may have difficulty engaging in genuine, empathetic conversations that will contribute positively to clients' treatment. Since most clients are fearful of being judged, they find comfort in their therapists' empathy. However, therapists' struggle to maintain large case loads on top of their other personal and professional responsibilities

can challenge their ability to express empathy toward their clients (Maslach & Leiter, 1997; Skovholt & Trotter-Mathison, 2011).

When therapists begin to feel cynical and negative, they can start questioning their capabilities, and their self-worth can spiral downward (Maslach & Leiter, 1997). Because of low self-worth, simple disagreements can easily morph into fights. Rudeness, sarcasm, insults, and criticism become more of the rule than the exception. The emotional lows of frustration and anger decrease therapist' quality of work to the point where burnout occurs and hinders not only their intimate and familial relationships, but also their social relationships (Maslach & Leiter, 1997).

After exhaustion, the next stage of burnout is depersonalization (Leiter et al., 2001; Maslach & Leiter, 1997). In this stage, people become isolated, disconnecting from the emotional support and nurturance of family and friends (Maslach & Leiter, 1997). As circumstances sour, therapists may cover up what they are feeling by presenting themselves as callous, resisting the help of others and gravitating toward isolation (Leiter et al., 2001; Maslach & Leiter, 1997). In the process, burnout rages like a brush fire, influencing others in the professional and personal arenas to withdraw from the negativity radiating from these therapists (Maslach & Leiter, 1997).

While in the depersonalization stage, therapists have trouble examining their clients' subjective experiences and thoughts without bias (Negash & Sahin, 2011). Depersonalization fosters negativity that leads to guilt and distress, ultimately preventing therapists from achieving personal victories (Maslach & Leiter, 1997). By objectifying their clients, therapists run the risk of misinterpreting clients' stories, providing useless and unrelated information, and working at a pace that is inappropriate for the clients'

situations (Negash & Sahin, 2011). Self-esteem and competence plummet to the point that fears and anxieties prevent therapists from focusing on present issues (Maslach & Leiter, 1997).

Fatigue often causes therapists to view their clients negatively, providing them with little motivation to deliver high quality services (Maslach & Leiter, 1997). The therapists' lack of motivation transfers to clients, causing them to lose interest in achieving their therapy goals (Negash & Sahin, 2011). Devoid of energy and commitment to their work, therapists become cold and uncaring, ultimately believing that they are failures (Leiter et al., 2001; Maslach & Leiter, 1997). Because of this dynamic, therapists become emotionally stuck and experience difficulties attaining feelings of accomplishment that hinder their efforts to get help from other people (Leiter et al., 2001). The symptoms of burnout are not just about the presence of negative emotions, but also about the absence of positive ones, like dignity and the spirit of the human soul (Grosch & Olsen, 1994; Maslach & Leiter, 1997; Skovholt & Trotter-Mathison, 2011).

Burnout Measures

Although burnout is a draining process that affects both the professional and personal lives of therapists, it functions as an indicator of what needs to be changed in the therapists' lives (Clark, 2009). The Maslach Burnout Inventory, the most widely used measure for burnout, assesses the degree to which people experience emotional exhaustion, lack of personal accomplishment, and depersonalization at work (Leiter et al., 2001; Maslach & Leiter, 1997; Rosenberg & Pace, 2006; Skovholt & Trotter-Mathison, 2011). The MBI is regularly used to rate burnout among social workers, psychologists, and psychiatrists (Rosenburg & Pace, 2006). According to the existing research, the

inventory has not been used extensively with MFTs, so their burnout experiences have not been well represented or explored. Rosenberg and Pace (2006) examined the appropriateness of using the MBI for measuring MFTs' rates of burnout and found it to be a good fit.

Why Community-Based Family Therapists Are Burning Out

Given the cultural diversity and socioeconomic circumstances among their clients, therapists are sometimes left feeling overwhelmed, ill-equipped, or incompetent in session as they struggle to keep up with the pace, content, and context of some of their cases (Frontes, Piercy, Thomas, & Sprenkle, 1998; Hamel & Laraway, 2004; McConaughy, 1987; Thomas, McCollum, & Snyder, 1999; Wolgien & Coady, 1997). Therapists quickly realize that professional training and education programs do not guarantee competence (Frontes et al., 1998; Hamel & Laraway, 2004; McConaughy, 1987; Thomas, McCollum, & Snyder, 1999; Wolgien & Coady, 1997).

Forcing individuals to favor economics over quality of life, burnout occurs when there is a mismatch between the nature of the job and the nature of the person doing the job (Maslach, 1982; Maslach & Leiter, 1997). Skovholt and Trotter-Mathison (2011) and Maslach and Leiter (1997) explain this further by saying that burnout is not a problem with people, but rather a problem with the social environment in which they work. For in-home therapists, the number of cases they have takes precedence over the quality of therapy they provide (Maslach & Leiter, 1997); therefore, pertinent questions like "What makes us tick?" and "What inspires us to work well and proficiently?" are ignored (Maslach & Leiter, 1997). As several previous researchers have pointed out, burnout

causes the attrition of values, dignity, spirit, and the human soul (Grosch & Olsen, 1994; Maslach, 1982; Skovholt & Trotter-Mathison, 2011).

Killian (2008) draws attention to the impact that excessive exposure to traumatic case material has on therapists' daily mindset. For 30 to 40 hours per week, therapists listen to and make sense of clients' traumas revolving around such issues as childhood sexual abuse, domestic violence, catastrophes, war, and terrorism (Killian, 2008). Because of this day-in, day-out exposure, therapists have a higher chance of developing acute distress and burnout (Killian, 2008). Killian reported, "in a study (Davidson and Smith, 1990) of outpatient mental health clients, 84% to 94% reported a history of traumatic events such as child sexual abuse, domestic violence, exposure to combat zones, and displacement" (p. 573). This sheds light on the level of intensity and high volume of traumatic case material shared by trauma survivors and the way therapists are affected during and after those therapeutic dialogues (Killian, 2008). Killian recommends that therapists develop a healthy psychological awareness to help lessen the negative effects on their psyches.

Lauderdale (1982) agrees with Killian (2008) and expands on the declaration that therapists should have a healthy psychological awareness to prevent burnout from occurring. When achievements do not match expectations, people are often unaware of how their dissatisfactions are affected by world events and experiences (Lauderdale, 1982). Changes throughout the world can have a ripple effect on the professional and personal aspects of therapists' lives, leading to uncertainty, contradiction, and stress that affect their visions of the world (Lauderdale, 1982).

There is still disagreement among researchers regarding what constitutes burnout. Though Freudenberger (as cited in Grosch & Olsen, 1994) was the first to define it, there is still no standard definition (Leiter, Maslach, & Schaufeli, 2001, Maslach, 1982; Skovholt & Trotter-Mathison, 2011). Burnout is generally considered to be a multidimensional syndrome with strong associations to work-related stress; however, there is still a great deal of uncertainty surrounding the identification of exact relational and situational factors that cause burnout to occur in both personal and professional environments (Appel & Appel, 2008; Maslach, 1982; Maslach & Leiter, 1997; Negash & Sahin, 2011; Skovholt & Trotter-Mathison, 2011).

The existing research points to general standards of behavior that can be considered indicators of therapeutic competence (McConaughy, 1987; Wolgien & Coady, 1997). These characteristics, both objective—e.g., age, sex, professional background—and subjective—e.g., personality, therapeutic philosophy—are attributed to well-adjusted individuals who are interested in helping and have exceptional relationship skills (Cluff & Binstock, 2001; Wolgien & Coady, 1997). The research on these qualities skews the focus and fails to address how therapists develop their helping abilities (Wolgien & Coady, 1997). This lack of information leads to the general assumption that professional education, training, and experience in the field will be enough for therapists to become capable of dealing with challenging situations presented in community-based agency settings (Wolgien & Coady, 1997). Even though there is a wealth of information on the topic of therapists' personal contributions to therapeutic processes and outcomes, there is an alarming absence of research pertaining to therapists' reasons for doing

therapy and the factors that contribute to the development of their therapeutic abilities (McConnaughty, 1987; Wolgast & Coady, 1997).

Becoming a community-based agency therapist often comes from a desire to work with children and families. This desire influences everything from the therapist's initial decision to enter the field, and continues through the therapist's selection of a philosophy of treatment and development of intervention strategies (Krueger & Powell, 1990).

Therapists push through the demanding responsibilities of their work, because they recognize that young lives hang in the balance and know they have to strive to make decisions that reflect empathy, compassion, trust, and security. The nature of the job requires therapists to assume other roles, such as scientist, artisan, and artist. Switching roles allow therapists to utilize a scientist's technical rigor and tenacious search for answers, an artisan's handwork and hours of practice, and an artist's ability to draw upon intuitive skills to create dynamic learning environments (Krueger & Powell, 1990). Therefore, being a therapist requires the individual to step outside his or her comfort zone and embrace the understanding of what it means to be human, have personhood, and practice the art of caring (Krueger & Powell, 1990).

Therapist must maintain a balance as they carry out their professional duties in community service agencies, not allowing those duties to infringe on their personal lives (Appel & Appel, 2008; Grosh & Olsen, 1994; Leiter, Maslach, & Schaufeli, 2001; Maslach, 1982, 1993). The relationships therapists have with their co-workers and clients, along with all the other emotional demands of their work, play an important role in forming their perceptions of excessive workload and stress (Appel & Appel, 2008). According to Maslach (1993), excessive demands—which result in stress—combined

with a lack of personal or relational coping resources, will lead to burnout. Research conducted on burnout and stress suggests that interpersonal processes and coping resources are critical components in the avoidance of individual distress and achievement of successful adaptation (Appel & Appel, 2008). Negative consequences naturally result from stress and have a spillover effect on therapists' family and peer relationships. Ultimately, stress negatively affects therapists' job performance, psychological and physical health, and relationships at work and home (Appel & Appel, 2008).

Utilizing the medical model approach, Grosch and Olsen (1994) describe how burnout symptoms, diagnosis, and prescriptions emphasize that occupational depletion is the result of being overworked. The primary cure for this would, therefore, be to work less and relax more (Grosch & Olsen, 1994). However, in light of today's harsh capitalistic, economic culture and psychological pressures, working less is often not an option (Grosch & Olsen, 1994; Leiter et al., 2001; Maslach, 1982). Personal time to relax and spend time with family time is rarely valued, and therapists are often forced to work harder, causing them to experience burnout earlier in their careers (Grosch & Olsen, 1994; Maslach, 1982). This lack of balance between therapists' professional and personal lives is even more tragic because the psychotherapeutic world knows burnout generates a slow and gradual depletion of the helping spirit, faith, passion, and hope at the professional level (Grosch & Olsen, 1994). Therefore, professional burnout not only affects therapists' personal lives, but also their professional effectiveness (Appel & Appel, 2008; Grosch & Olsen, 1994; Leiter, Maslach, & Schaufeli, 2001; Maslach, 1982).

Turnover

Unsatisfactory work conditions and poor job satisfaction cause burnout, which ultimately leads therapists to leave their jobs (Acker, 2004; Davis, 2013; Greenson, Guo, Barth, Harley, & Sission, 2009; Gupta, Peterson, Lysaght, & Zweck, 2012). Rising treatment costs, increasing health care utilization, and massive healthcare industry debt have all radically changed the American health care system (Greenson et al., 2009; Gupta et al., 2012). The implementation of financial services has changed the system, resulting in increased case loads, reduced funding, lowered salaries, and limited opportunities for continuing education (Acker, 2004; Davis, 2013; Greenson et al., 2009; Gupta et al., 2012). Therapists are restricted by cost containment and strict practice guidelines set by third party payers and insurers (Acker, 2004, Skovholt & Trotter-Mathison, 2011). Attention needs to be focused on how to increase therapists' job satisfaction, making them more likely to stay at community-based agencies. It is also important to determine what can be done to heighten the quality of services at community-based agencies (Acker, 2004; Davis, 2013).

According to research conducted on burnout and job satisfaction over the past 30 years, work-related stress leads to job dissatisfaction, low organizational commitment, absenteeism, and high turnover (Gupta et al., 2012). It is estimated that the “. . . annual turnover rate among mental health and human services agencies often exceeds 25% of therapeutic staff . . . and some estimates have exceeded 50% turnover of qualified therapists” (Greenson et al., 2009, p. 240). The organizational costs associated with turnover apply to recruitment, new employee training, quality of services, and documentation procedures (Greenson et al., 2009). Because of the extremely stressful

nature of these jobs, therapists struggle to maintain a balance among their priorities in the clinical and non-clinical aspects of their lives (Gupta et al., 2012).

Various studies have been conducted to explore the causes of turnover, and the results are varied, indicating a wide range of possible explanations including financial circumstances, role ambiguity, elevated stress levels, and lack of social support management (Greenson et al., 2009; Gupta et al., 2012). Some of the most common reasons given for leaving voluntarily ranged from obtaining new employment to being dissatisfied with the job or seeking higher pay (High rates of job, 2010). In the substance abuse treatment field, “not only were voluntary annual turnover rates in the 27 organizations markedly higher than the average throughout health care and social assistance professions—which the Bureau of Labor Statistics puts at about 20 percent—but 36 percent of counselors who quit their jobs left the field altogether” (High rates of job, 2010, p. 1). With burnout and stressful work environments having a catalytic effect on therapy, low job satisfaction, and decisions to leave, community-based agencies are forced to make organizational adjustments that increase costs for therapy while decreasing efficiency and morale (High rates of job, 2010). All of this leaves clients feeling the brunt of it all (Greenson et al., 2009; High rates of job, 2010).

Because it will take time to develop, implement, and produce effective strategies to improve turnover rates, researchers appear to be focused on increasing understanding of the impact that provider turnover has on youth and families (Greenson et al., 2009; High rates of job, 2010). These findings need to be directed toward improving the effectiveness of therapeutic relationships (Greenson et al., 2009).

Greenson, Guo, Barth, Harley, and Sission (2009) examined the factors that influenced post-discharge outcomes. They collected data from 1,416 youth and 412 therapists from a behavioral health service organization (Greenson et al., 2009; High rates of job, 2010;). They identified a positive correlation between therapists' level of education and their stability (Greenson et al., 2009; High rates of job, 2010). Therapists with more education were likely to have positive one-year post-discharge outcomes. (Greenson et al., 2009). Master's degree level therapists had a 5% greater likelihood of being stable than therapists who did not. However, to avoid implying that having a master's degree is an absolute predictor of therapist stability, Greenson et al. stressed that further investigation needs to be done before making statements regarding hiring practices.

Davis (2013) examined variable predictors that were likely to lead to job satisfaction for providers working on professional treatment teams in community mental health centers. He found that there were two variables shown to be significant predictable factors of job satisfaction among these peer providers: role clarity and psychological empowerment. Peer providers' job satisfaction was also found to be related to their psychological empowerment. This model of motivation in the workplace places a premium on benefits received from peer support services, which leads to increased self-esteem (Davis, 2013). Psychological empowerment showcases the importance of having an impact in the work environment, having the independence to organize and perform meaningful work. Peer providers are motivated and inspired by this sense of power to control the work environment and themselves (Davis, 2013).

The literature suggests that micromanaging policies and procedures contribute to therapists feeling limited as they struggle to work with clients and implement policies and procedures in the human service delivery system (Rosenburg & Pace, 2006).

Inconsistencies and lack of fluidity in how therapists are forced to present themselves cause them to view their professional activities as inappropriate and incongruent with their training, professional expertise, and desires (Acker, 2004). Therefore, the aim of this qualitative study is to explore what works for successful in-home family therapists working at community-based agencies.

Coping Methods

The existing literature indicates that community-based family therapists utilize coping mechanisms as a means of managing their stresses and preventing burnout. The coping mechanisms that will be explained in this next section are as follows: (1) formal training (Bateson, 1991; Boyd-Franklin & Bry, 2000; Christensen, 1995; Cluff & Binstock, 2001; Hamel & Laraway, 2004; Killian, 2013; Negash & Sahin, 2011; Paris, et al., 2006; Rosenburg & Pace, 2006; Thomas et al., 1999; Trudeau et al., 2001); (2) clinical experience (Corey, Corey, & Callanan, 1998; Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004; Thomas et al., 1999); (3) being human (Buscaglia, 1978; Clark, 2009; Krueger & Powell, 1990; Protinsky & Coward, 2001); (4) resiliency (Aponte, 1991; Aponte & Winter, 2000; Appel & Appel, 2008; Clark, 2009; Grosch & Olsen, 1994; Hamel & Laraway, 2004, 2009; Kuiper, 2012; McConaughty, 1987; Negash & Sahin, 2011; Paris et al., 2006; Piercy, Thomas, & Sprinkle, 1998; Protinsky & Coward, 2001; Shamai, 2005; Rosenburg & Pace, 2006; Wolgast & Coady, 1997); and (5) resilient attitude (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000;

Clark, 2009; Hamel & Laraway, 2004; Kuiper, 2012; Protinsky & Coward, 2001; Rosenberg & Pace, 2006; Wolgast & Coady, 1997).

Formal Training

Formal training is an obvious requirement for providing therapeutic services at community-based agencies (Bateson, 1991; Boyd-Franklin & Bry, 2000; Christensen, 1995; Cluff & Binstock, 2001; Hamel & Laraway, 2004; Killian, 2013; Negash & Sahin, 2011; Paris, Linville, & Rosen, 2006; Rosenberg & Pace, 2006; Thomas et al., 1999; Trudeau et al., 2001). For the purposes of this study, formal training consists of the following: (1) interactional view (Bateson, 1991; Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007); (2) Code of Ethics (AAMFT, 2015; Gladding, Remley, & Huber, 2001; Guise, 2009); and (3) clinical experience comprised of therapy and supervision experience (Corey, Corey, & Callanan, 1998; Edward & Patterson, 2006; Hamel & Laraway, 2004; Thomas, et al., 1999).

Previous researchers have identified that interactional views and the AAMFT Code of Ethics (AAMFT, 2015) provide MFTs with a conceptualization of what therapy is and how it is done; however, clinical experiences, both therapeutic and supervisory, are what provide therapists with understanding of actually practicing therapy, being in the moment with clients (AAMFT, 2015; Corey et al., 1998; Edward & Patterson, 2006; Gladding et al., 2001; Guise, 2009; Hamel & Laraway, 2004; Thomas et al., 1999). I will provide a brief description of each of these concepts in the following sections.

Interactional View

The ultimate goal in the formal training of graduate students is to help them understand how to do therapy in a manner that highlights the interactional view (Bateson, 1991; Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007). The interactional view functions as the basic foundation for understanding not only how therapeutic models and techniques guide the therapeutic process, but also how therapists should help clients find new ways to look at old problems (Bateson, 1991; Nelson & Thomas, 2007; White, 2007). The interactional view speaks to the in-the-moment therapeutic interaction that reflects the crucial elements of curiosity, respect, and tentativeness (White, 2007). Implemented in all of the MFT models, researchers will discuss each of these concepts through the theoretical lens of Solution-Focused Brief Therapy (SFBT) (Berg, 1994; Berg & Dolan, 2001; Miller & Berg, 1995; Nelson & Thomas, 2007) and narrative therapy (Freedman & Combs, 1996; White, 2007).

Curiosity is an indispensable quality for family therapists. Both SFBT and narrative therapy encourage therapists to utilize curiosity as a means of pushing through their feelings of unfamiliarity in order to address the problems their clients face (Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Lipchik, 2002; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007). However, they each promote unique therapeutic techniques that serve as a means of utilizing therapists' curiosity in the process of learning from their clients. From a SFBT point of view, curiosity is directed towards positive outcomes, partial success, and clinical client-contextual resourcefulness (Berg, 1994; Berg & Dolan, 2001; Miller & Berg, 1995; Nelson & Thomas, 2007).

Narrative therapy acknowledges clients as the experts in their own life stories and is thus centered on the belief that they ultimately decide which aspects of their lives to deconstruct and re-story (Freedman & Combs, 1996; White, 2007). Within the narrative tradition, the therapist's focus is centered on co-creating dialogues geared towards addressing the topics of who will be involved in therapy, the issues discussed in the therapy, and the importance of the history pertaining to therapeutic issues presented in session (Berg & Dolan, 2001; Freedoman & Combs, 1996; Lipchik, 2002; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007).

In the process of therapy, therapists demonstrate respect as they learn about the complexities involved in their clients' lives (Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Lipchik, 2002; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007). The SFBT and narrative therapy approaches both acknowledge that clients and their families have complex lives that are multidimensional in terms of culture, religion, values, morals, and traditions (Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Lipchik, 2002; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007). Through encouraging clients to share their stories, therapists are able to join with the clients, acknowledging their pain and hardships, re-establishing hope, and indirectly letting them know it is okay to let their guard down (Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Lipchik, 2002; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007). In cases in which clients are struggling with acculturation issues, dominant narratives of their unique cultural traditions prevail over Western social narratives involved in the circumstances (White, 2007).

Embracing a not-knowing, non-judgmental stance, therapists portray themselves as being tentative (Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Lipchik, 2002; Nelson & Thomas, 2007; White, 2007). Demonstrating curiosity rather than ignorance, therapists relay their tenacious attitude through their line of respectful questioning (Nelson & Thomas, 2007). It is essential that therapists educate themselves by inquiring about clients' lives so as to gain an understanding of their world in the context of the therapeutic issues they present (Berg, 1994; Berg & Dolan, 2001; Freedman & Combs, 1996; Lipchik, 2002; Miller & Berg, 1995; Nelson & Thomas, 2007; White, 2007). Therapists position themselves to be informed by their clients to learn about what is being said and what is not being said (Nelson & Thomas, 2007; White, 2007).

Bateson (1991) elaborates on the power of language in how therapists communicate with clients in therapy. According to Bateson, language is a monstrous thing, because you never know what "it" really is; however, it functions as a useful tool that relies on the organization and order of what is being said to decipher meanings. Instead of focusing on the tangles of presumptions, Bateson emphasizes that therapists' focus should be geared toward looking at the nature of systems from a holistic perspective. In doing so, they can capture a descriptive and relational representation of the context of the system explaining how people become engrossed in the habit of thinking materialistically and gravitating towards quick fix options.

According to Bateson (1991), therapists should not focus solely on techniques but on theory as well. He stressed that "... theory is not just another gadget which can be used without understanding" (Bateson, 1991, p. 278). Instead, he encouraged therapists to

be aware of the theoretical foundation supporting the techniques they use so as to avoid reliance on the quick fix approach when frustrations accumulate due to failed interventions (Bateson, 1991). As illustrated by the both/and concept promoted in the SFBT approach, awareness of both theory and technique becomes a crucial component of therapists' competence in therapy (Bateson, 1991; Berg, 1994).

Conceptualized as an evolutionary business, Bateson (1991) shed light on the fact that we live in a world comprised of relational patterns, ideas, theories, and communication. Having a curious relationship, ideas allow for description, distinction, and perspective development to emerge and grow. Bateson asserts:

The business of thinking, the business of learning, becomes very much the business of evaluation when you realize that it is all the time partly experimental—feeling, grasping, expanding... It is called trial and error (it should be called success and error, shouldn't it?) among which you then find your way. (p. 278)

Bombarded with new information, people find themselves in double binds as they attempt to adapt to multiple relationships simultaneously occurring with themselves and other individuals (Bateson, 1991). Flemons (1991) connects to Bateson's perspective by explaining how the double bind phenomenon provides a contextual description of conflicting demands. He states:

If solving a problem of learning or adaptation at one contextual level thereby creates a problem at a more encompassing contextual level (thus undermining the original solution), the tangled situation as a whole can be described as a double bind: 'The organism is faced with the dilemma either of being wrong in the

primary context or of being right for the wrong reason or in a wrong way.

(Flemons, 1991, p. 7)

Using metaphors, stories, challenges, and humor, therapists can answer questions indirectly, leading to a whole new category of inquiry as answers to original questions are being deciphered (Flemons, 1991). Therefore, evolution is seen as a systemically interlocked business involving operations of relationships and changes yielding to the desired need to adapt (Bateson, 1991; Flemons, 1991).

Code of Ethics

Training in the AAMFT Code of Ethics is part of the graduate curriculum for family therapy students (AAMFT 2015; Gladding et al., 2001; Guise, 2009). Upon completion of their formal training, therapists are expected to competently practice therapy in accordance with a clear understanding of the Code of Ethics (Guise, 2009). Since obtaining a license does not guarantee competency in the practice of ethics (Gladding et al., 2001), therapists are encouraged to follow regulations and ethical guidelines based on state requirements to safeguard their reputations (Guise, 2009). In this section, I will explore four core areas of the AAMFT Code of Etthics: (1) determining who therapy serves, (2) handling secrets, (3) diagnosing labels, and (4) defining inappropriate use of power (AAMFT, 2015; Gladding et al., 2001; Guise, 2009).

Determining who therapy serves. According to the AAMFT (2015) Code of Ethics, the client is defined as the individual seeking therapy and his or her relatives (Gladding et al., 2001; Guise, 2009). Given that MFTs' training backgrounds are heavily focused on family systems and relationship dynamics, treatment designs are inclusive of the family members involved in the presenting problem so as to fully the relational

context of the problem. Furthermore, non-blood familial relatives, such as friends, case managers, social workers, and teachers are allowed to be participate in sessions only if the client approves of their participation in writing (AAMFT 2015; Gladding et al., 2001; Guise, 2009). The AAMFT Code of Ethics underscores the importance of therapists maintaining meticulous documentation for everyone involved in the therapeutic process, including both blood related and non-blood related family members

Handling secrets. Another area of concern regarding ethics pertains to handling secrets surrounding circumstantial issues of confidentiality and neglect and abuse (AAMFT Code of Ethics, 2015; Gladding et al., 2001; Guise, 2009). In abuse and neglect cases, therapists find themselves in awkward circumstances regarding secrets that when revealed in session are considered part of the therapeutic conversation and documented as such. To ease the exacerbation of the problem, therapists supportively encourage their clients to reveal secrets in session with their family members present so as to lessen the overall emotional and mental weight associated with the secret (AAMFT, 2015; Gladding et al., 2001; Guise, 2009). In cases of neglect and abuse, therapists function as advocates for their clients and are compelled by the duty to warn to break confidentiality by notifying authorities (AAMFT, 2015; Gladding et al., 2001; Guise, 2009).

Diagnosing labels. The next issue regarding ethics involves the concept of diagnosing labels (AAMFT, 2015; Gladding et al., 2001; Guise, 2009). The Code of Ethics recognizes the documentation protocols regarding sharing clients' information with other systems, such as insurance companies and the courts regarding issues such as divorce, custody, and abuse (AAMFT, 2015; Gladding et al., 2001; Guise, 2009).

Inappropriate use of power. The last ethical issue pertains to inappropriate use of power in therapy as well as supervision (AAMFT, 2015; Gladding et al., 2001; Guise, 2009). Inappropriate use of power occurs when therapists violate clients' therapeutic rights by posturing themselves during therapy in a manner that is disrespectful (Gladding, Remley, & Huber, 2001; Code of Ethics, 2008; Illinois Institute of Technology, 2010). Abuse of power includes racial slurs, discriminatory actions, insulting gestures, inappropriate touching of any kind, and sexual acts conducted during session by therapists towards clients (AAMFT, 2015; Gladding et al., 2001; Guise, 2009). Therapists are encouraged to communicate in a careful and respectful manner and be conscientious of their clients' vulnerabilities in addition to their cultural, ethnic, and gender values (AAMFT, 2015; Gladding et al., 2001; Guise, 2009). To avoid abusing their power, community-based therapists are required to receive supervision supervision (AAMFT, 2015; Gladding et al., 2001; Guise, 2009).

Clinical Experience

Therapists' formal training requires them to demonstrate their comprehension of the aesthetics and pragmatics of therapy; they apply this knowledge through early clinical experiences consisting of internships, supervision, and work at community-based agencies (Corey et al., 1998; Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004; Thomas et al., 1999). In the next section, I will divide therapists' experiences into two categories: (1) internship and work experience (Corey et al., 1998; Edward & Patterson, 2006; Hamel & Laraway, 2004; Thomas et al., 1999) and (2) supervision (Corey et al., 1998; Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004).

Internships and work experiences. Internships and work experiences allow therapists to go through the processes of self-development that combine ecosystemic perspectives, life, and clinical competence with their humanity (Corey et al., 1998; Edward & Patterson, 2006; Hamel & Laraway, 2004; Thomas et al., 1999). Typically, after the third year of graduate school, therapists get their first opportunities to practice therapy in initial immersion processes at campus clinics (Hamel & Laraway, 2004). Through on-site clinical practice, therapists are trained to understand structural dynamics, policies and procedures, note taking, and assessment completion (Hamel & Laraway, 2004; Thomas et al., 1999).

Therapists' internship experiences involve immersion in community-based agencies that expose them to a wide array of multicultural issues (Hamel & Laraway, 2004; Thomas et al., 1999). In-home and on-site programs at community-based agencies provide therapists with a variety of experiences as they navigate through therapy, individual and group supervision, trainings, meetings, and case staffing (Corey et al., 1998; Hamel & Laraway, 2004; Thomas et al., 1999). Relying on their professional training and personal skills, community-based therapists must constantly multitask and fluctuate between reacting and adapting quickly in therapy so as to decrease client anxieties and increase the chances of positive therapeutic outcomes (Corey et al., 1998; McCollum & Snyder, 1999).

Community-based therapists often feel overwhelmed by the number of hours they dedicate to managing their case loads with limited resources and little self confidence due to feeling discouraged and disempowered by their own frustration and inability to be as helpful to their client families as they would like to be (Thomas et al., 1999). In-home

therapists struggle with conducting therapy at clients' homes mainly due to issues pertaining to the social atmosphere, boundaries, and session timing. Overall, the stress associated with working at community-based agencies leaves therapists feeling drained. Many therapists burn out due to the constant multi-tasking required for doing tasks that fall outside their job description, such as tutoring and babysitting (Hamel & Laraway, 2004; Thomas et al., 1999).

Supervision. Supervision gives therapists an opportunity to get feedback about their clinical work and areas in which they may need to improve (Corey et al., 1998; Edward & Patterson, 2006; Hamel & Laraway, 2004). The supervisory setting provides feedback in accordance with licensure requirements (Corey et al., 1998; Edward & Patterson, 2006; Hamel & Laraway, 2004). Therapists sometimes experience countertransference in the supervision process (Corey et al., 1998; Edward & Patterson, 2006; Hamel & Laraway, 2004). Focusing on a wide array of clients issues, therapists find themselves stuck in countertransference experiences because of their own unresolved experiences (Corey et al., 1998; Hamel & Laraway, 2004).

Discussing cases with interns, colleagues, and staff through supervision and peer consultation becomes a means for therapists to successfully alleviate their nagging doubts associated with their own feelings of being overwhelmed (Hamel & Laraway, 2004). Supervisors may encourage therapists to keep journals of their experiences, help manage their caseloads, and construct personal genograms to recognize patterns within their lives in relation to their families of origin (Corey et al., 1998; Fontes et al., 1998). Acknowledging the harshness of many work environments—hospitals, community agencies, universities—and the absence of resources in those environments—due to

inadequate funding, professional competition, and poor facilities—Frontes, Piercy, Thomas, and Sprenkle (1998) recommend that training programs and employers provide family therapists with weekly mentoring, positive acknowledgement, success celebrations, and opportunities to set and evaluate goals.

The therapeutic relationship dictates the maintenance of ethical standards, and the power of language heavily influences the interactional dynamics between supervisors and supervisees (Bateson, 1991; Edwards & Patterson, 2006; Guise, 2009). Supervision must be conducted respectfully to avoid demeaning the supervisee's culture and religion (Edwards & Patterson, 2009; Guise, 2009). Supervisors are expected to conduct supervision with respect, curiosity, open-mindedness, multicultural awareness, and theoretical awareness related to their field (Edwards & Patterson, 2009; Guise, 2009). Supervisors who are familiar with supervisees' work settings are able to appreciate the influence of the background and work environment on the supervisees' clinical work (Edwards & Patterson, 2009; Guise, 2009). In the process, supervisors become aware of the dilemmas and other factors that are part of the supervisee's world (Edwards & Patterson, 2006).

By getting feedback, therapists get a more accurate view of how their jobs have changed them (Leiter, Maslach, & Schaufeli, 2001; Negash & Sahin, 2011; Paris et al., 1006; Skovholt & Trotter-Mathison, 2011). To compensate for these changes, supervisors, co-workers, friends and families might recommend reducing caseloads, participating in informal mentoring, attending educational retreats and conferences, and taking personal time to reduce the effects of burnout (Leiter, Maslach, & Schaufeli, 2001; Negash & Sahin, 2011; Paris et al., 1006; Skovholt & Trotter-Mathison, 2011).

Furthermore, it is recommended that therapists attend and present at annual conferences as a means of learning new techniques and strategies they can implement in therapy (Killian, 2008; Leiter et al., 2001; Negash & Sahin, 2011; Paris et al., 2006; Skovholt & Trotter-Mathison, 2011).

There is no definitive way to perform supervision, but there are some essential characteristics that are necessary for it to be successful: knowledge, experience, and open-mindedness (Corey et al., 1998; Guise, 2009; Hamel & Laraway, 2004). Gained through theoretical and ethical aspects of training programs, the knowledge of supervision surrounds the implementation of the supervisor-supervisee relationship, functioning as an agent in moving supervisees through their stuck points (Corey et al., 1998; Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004;). Therapists in supervision are free to verbalize their concerns about the areas in which they feel that they are not making progress. They can express their frustrations and voice their concerns about their clients' actions and reactions during the therapeutic process (Corey et al., 1998; Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004). In nonjudgmental and respectful settings, supervisors provide feedback to clients—individually or in groups—and recommend new strategies, techniques, and resources. Supervisors will notice themes and trends in the ways that therapists conduct sessions and identify instances of countertransference (Corey et al., 1998; Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004).

Simon (2006) discusses how a therapist's worldview serves to help him or her bypass the constraints of the various therapeutic models, focusing on interpersonal variables that make up the person of the therapist. This framework acknowledges that

therapists are regular people who enter the therapeutic encounter with an amalgamation of their own personal issues mixed with the internalization of their previous therapeutic encounters (Simon, 2006). As such, therapists' worldview transforms their personal models into instruments of deep, real, authentic self-expression, allowing them to maximize the effectiveness of therapy (Simon, 2006).

Being Human

Addressing therapists' reasons for choosing their profession requires that attention be focused on the notion that therapists, like their clients, are human (Buscaglia, 1978; Clark, 2009; Krueger & Powell, 1990; Protinsky & Coward, 2001). The interpersonal elements of style, character, culture, and life experience combined with the relationship factors of warmth, friendliness, and empathy all function as primary determinants of therapeutic effectiveness (Wolgien & Coady, 1997). Some therapists are consistently more effective than others, given the relationship skills and helpful attitude they naturally possess. Culture, ethnicity, race, and even socioeconomic status function as unconscious labels for systemic values through which therapists—and people, in general—interpret their reality and guide their behaviors (Wolgien & Coady, 1997).

More attention needs to be focused on how therapists' inner experiences and general life experiences shape their clinical work and professional successes (Protinsky & Coward, 2001). Protinsky and Coward (2001) focus their work on addressing the personal and professional development of MFTs. They discuss the importance of experiences shaping and molding therapeutic growth, development, and success (Protinsky & Coward, 2001). Addressing the topic of seasoned therapists in his research, Nacross (1996) explores the merger of therapists' personal and professional lives in a

way that enhances their therapeutic abilities. By interviewing diverse psychotherapists, he discovered that therapists' most important lessons came from years of professional practice and research highlighting the importance of going through personal changes and engaging in effective self-nurturing as they progress. Graduate students can benefit from this research, as it can aid them in the context of therapy.

Therapy may be viewed as a personal relationship that is framed by professional parameters (Aponte, 1985). Values from the entire therapeutic process allow transactions between therapists and clients to resemble a negotiable exchange about respective value systems that each party brings into the therapeutic relationship. As such, therapists play active roles in directly and indirectly giving their opinions, sharing judgments, and making suggestions. Cultures, values, and morals are key elements in understanding people and learning how to work with them (Aponte & Carlsen, 2009). Cultural dialogue allows for therapeutic interplay between therapists and clients to learn what works professionally and personally (Aponte & Carlsen, 2009; Protinsky & Coward, 2001). The results of qualitative studies on therapists' subjective can help therapists in training learn how to conduct therapy while simultaneously exploring their growth and development in the process (Protinsky & Coward, 2001). Therapists' goals are to understand and intervene in families' lives by defining and interpreting repetitive personal issues. Thus, therapy becomes a process that is shaped by the interactions of therapists' personal values with those of the community-based agencies (Aponte, 1985).

Self-awareness and self-assessment play an integral role in establishing balance between the personal and professional aspects of therapists' lives (Buscaglia, 1978; Clark, 2009; Krueger & Powell, 1990; Protinsky & Coward, 2001). Protinsky and

Coward (2001) and Buscaglia (2009) explain that instead of viewing life experiences as something that should be compartmentalized away from therapeutic experiences, they should instead be merged moments of lessons learned—an appreciation for who they are as therapists. Describing life as an immense journey, Buscaglia (1978) and Clark (2009) emphasize the importance of making the present count by living in the moment as a means of being relentless in the process of molding, growing, and modifying oneself through the intertwining relationships in which they are presently involved.

These unique originate from diverse backgrounds and form a common representation of humanity's deep-seated need to survive (Buscaglia, 1978). An understanding of the world and how we are a part of it can be shared through dialogue about love and loneliness. Therapists may become emotionally misled and confused, both professionally and personally, when therapeutic content and context reminds them of past failures. Challenged by their circumstances, community-based agency therapists are often forced to rely on their natural instincts and resources to propel themselves forward with clients (Buscaglia, 1978).

Elaborating more on this, Toson, Nuttman,-Shwartz, and Stephens (2012) explain that therapists, like their clients, are affected by current events and changes in their environments. Climate change, worldwide terrorism, and the increasing frequency of man-made and natural disasters are examples of the types of content therapists find themselves exposed to when practicing therapy in traumatogenic environments (Toson et al., 2012). A shared traumatic experience heightens and strengthens the level of intimacy in the therapy positively by transforming the therapeutic experience into supportive experiences for therapists and clients. Awareness of catastrophic environmental events

ranging from hurricanes and earthquakes to shootouts and rapes alter the way people view the world and themselves in relation to it. While boundaries are blurred in such circumstances, it is possible for therapists to harness them in a way that is beneficial to treatment. They can create a therapeutic space in which they no longer assume superior roles but instead become acutely aware of subtle changes happening in their clients' lives and their own.

Aponte (1996) explains the spiritual dynamic within the mental health sciences, describing the resurgence of interest in this aspect of therapy, which appears in writings, new forms of therapy, and official psychological debates. Much of the world has adapted to some form of spirituality, and that adaptation has become an integral component of philosophies of healing. Today's social struggle over values puts therapists in the challenging position of explaining and justifying how therapy influences the values, morals, and worldview of people, families, and communities. People's belief systems speak to issues of human nature, the purpose of life, and our relationships to the world. As such, spirituality drives people's connections with social systems such as politics, culture, ethnicity, race, and religion.

If therapists can translate their beliefs into moral guides, they serve as real sources of strength and inspiration (Aonte, 1996). Therapists need to be trained to recognize their own views about social values, personal morality, and philosophical understanding of how therapeutic models reflect their particular biases. Aponte (1996) stressed that spirituality plays an integral role in defining the priorities, obligations, and roles of people in society; it becomes an essential ingredient in formulating the foundations of both personal psychology and relationship building.

The work of Milton Erickson explores how therapists can increasingly utilize their own experiences and practice hypnosis to help their clients (O' Hanlon & Martin, 1992). Within the context of hypnosis, therapists utilize clients' presenting behaviors and incorporate stories as aids to strengthen the therapeutic relationship (Erickson, 2009). Erickson (2009) advocates for discussions that support therapeutic goals of behavior change, sensory response, and consciousness so that clients can extend their range of experiences to provide for new ways of thinking, feeling, and behaving. Believing that people have a natural desire to grow, Erickson utilizes hypnosis to highlight people's natural abilities, helping them tap into their more instinctive, creative, and wiser selves (O' Hanlon & Martin, 1992). Hypnosis encourages small changes that result in larger transformations in clients' lives (Erickson, 2009; O' Hanlon & Martin, 1992).

The challenge is to uncover, develop, and hold on to our unique selves by being fully aware, sensitive, and flexible (Buscaglia, 1978). Therapists, like the individuals they encounter daily, live in complex societies and are engaged in the process of becoming (Buscaglia, 1978). Therapists must avoid blaming others and take responsibility for creating their own lives, no matter how painful and frightening that might be. In the process, they will realize that working on themselves is as valuable as their formal education (Buscaglia, 1978).

To develop an understanding of human systems and relationships in community-based settings, therapists must realize that the systems they work with are intertwined with other familial, community, cultural, and governmental systems, all of which have a common goal of solving problems and pursuing set objectives goals (Buscaglia, 1978; Krueger & Powell, 1990). As such, the effectiveness of the organizations are

interconnected with the actions of all members, clients, and constituents involved (Krueger & Powell, 1990).

Personhood

According to Buscaglia (1978) and Pearlman and Saakvitne (1995), personhood is the practice by which people implement who they are as individuals into what they do professionally. This includes combining personal relationships, values, beliefs, emotions, fears, and doubts with professional education and training experiences (Clark, 2009; Hamel & Laraway, 2004; Kuiper, 2012; Protinsky & Coward, 2001; Rosenberg & Pace, 2006; Wolgast & Coady, 1997). This unique approach allows therapists to build stronger rapport with clients. Successful therapy depends on therapists' willingness to create naturally flowing, less rigidly controlled experiences (Clark, 2009; Hamel & Laraway, 2004; Kuiper, 2012; Protinsky & Coward, 2001; Rosenberg & Pace, 2006; Wolgast & Coady, 1997).

Agreeing with the use of personhood in sessions, Paris, Linville, and Rosen (2006) highlight the necessity for balance between the professional and personal by focusing their study on the neglected topic of understanding how the personal and private lives of therapists function to create personal growth. Paris et. al. (2006) examined the significant synthesis of personal and professional selves among MFTs. They define synthesis as an integration of therapists' professional and personal selves, which creates a balance characterized by developmental and motivation awareness, self care, resiliency, and attention (Paris et al., 2006). The researchers divide personal and professional development into two categories: (1) experiences in therapists' personal lives that

influence clinical development and (2) experiences in therapists' professional lives that influence their growth as people.

According to Paris et al. (2006), because therapists' personal lives both directly and indirectly impact their work, the relationships they have with their families act as the basic training grounds for developing an understanding of the systemic functioning of families, developing helping skills, communicating with others, and developing effectively as therapists. They become better at differentiation and adaption as a function of the work they do with clients. By embracing the view that the personal influences the professional, therapists are able to attain freedom in their clinical work (Paris et al., 2006).

Clark (2009) identifies a lack of literature on the topic of resiliency among MFTs. He identifies the processes that allow MFTs to remain resilient, highlights factors that contribute to their longevity in the profession, and notes two primary implications for newer therapists: integration of self and integration of practice. Clark emphasizes that the use of self is not something associated with aesthetics and pragmatics, but rather with the essence of who therapists are.

Art of Caring

Therapists are expected to be well-versed experts in the art of caring (Cluff & Binstock, 2001; Kruegar & Powell, 1999). Those who work at community-based agencies describe their in-home services as caring for people in ways that encompass elements of compassion, comfort, communication, empathy, trust, and respect (Cluff & Binstock, 2001). Community-based therapists provide care that is natural and ethical. From an institutional perspective, care does not require emotion; it simply involves

performing required tasks to meet goals. However, caring cannot be separated from the dynamic that centers on the human relationship between caregiver and care recipient. Thus, caring functions as the actual act of providing care so that the caregiver's mental, emotional, and physical efforts support, advocate for, and validate people (Cluff & Binstock, 2001).

Originating in the heart of medicine, the art of caring is a powerful driver in relieving pain and suffering and reducing biological vulnerability to decline and decay (Cluff & Binstock, 2011). Vulnerability is a major theme replayed within many physical and emotional forms of medical treatment. Medical doctors and therapists address vulnerability and suffering, but the propelling force of caring is still the essential element in the treatment. The art of care allows for a general perspective of life that includes “. . . maximization of functioning mentally and physically, the prevention of dependency and the pursuit of autonomy, the relief of pain and suffering, a sense of physical and psychological security, and the realization of psychological and spiritual needs” (Cluff & Binstock, 2001, p. 15). According to Cluff and Binstock (2001), caring really is the solution when nothing else from modern medicine can be applied to relieve feelings of vulnerability and when loss of control sets in. When a treatment provider demonstrates empathy, validation, and acknowledgement to an ailing person, it acts as steady nourishment, easing the sense of vulnerability that arises from feeling alone. By providing aid that attends to patients' psychological and spiritual needs, caregivers restore their spirits.

Cluff and Binstock (2001) describe the four levels of caring that are always needed to avoid surrendering to the psychological and physical attributes of vulnerability.

The first level is known as the cognitive level of caring; it relates to the need to be understood by others. The second level involves the feelings and emotions associated with fear, anxiety, and depression. The third level focuses on goals, commitments, and values. The fourth level is the relational level that speaks to how a person in need of care and caring sees relationships with other people. The nature of caring is complex, interconnected, and reflective of people's capacity to be resilient.

Skovolt and Trotter-Mathison (2011) describe the art of caring as an issue that addresses how for therapists, like other practitioners, a lack of resiliency reflects the larger dilemma of caring for others versus caring for self. Therapists become emotionally attuned and sensitive to the needs of others due to their perspectives on helping, teaching, and healing processes as a constant requirement for success. Like other helping professionals, therapists often are so involved in caring and helping that they struggle to strike a proper balance in how they position themselves in relation to their clients. Therapists often lose sight of their proper role in the process of therapy.

According to Skovolt and Trotter-Mathison (2001), it is not natural to put others before oneself; yet, therapy often puts therapists in this position. They explain that the human senses—smell, sight, taste, touch, sound—function to protect and promote the self: “To know the world through the senses of others is like swimming upstream, naturally hard and easy to resist” (Skovolt & Trotter-Mathison, 2011, p. 4). To maintain professional vitality and avoid becoming depleted, it is crucial for therapists to establish boundaries between their personal needs and the needs of others (Clark, 2009; Maslach & Leiter, 1997; Skovolt & Trotter-Mathison, 2011). Bateson (1991) describes feedback loops and explains their purpose, which is to maintain homeostasis. Therapists can apply

the same positive and negative feedback loops to themselves to increase their awareness of the danger of overworking themselves if they do not attend to their own needs.

Therapists who are overworked suffer from fatigue and burnout. To do their jobs effectively, therapists need to remember that part of their job is taking care of clients, but the other part is taking care of themselves (Bateson, 1991; Skovolt & Trotter-Mathison, 2011). They need to use resources to strengthen themselves and avoid becoming overwhelmed by their clients' needs (Skovolt & Trotter-Mathison, 2011).

Resiliency

Much of the literature identifies resiliency as an ongoing journey; it portrays therapists who avoid burnout as constantly energized in their professional and personal lives (Aponte, 1991; Aponte & Winter, 2000; Appel & Appel, 2008; Clark, 2009; Grosch & Olsen, 1994; Hamel & Laraway, 2004; Kuiper, 2012; McConaughy, 1987; Negash & Sahin, 2011; Shamai, 2005; Paris et al., 2006; Piercy et al., 1998; Protinsky & Coward, 2001; Rosenburg & Pace, 2006; Wolgien & Coady, 1997;).

The concept of resiliency revolves around identifying the positive characteristics, strengths, and resources that will determine how therapists interact in therapeutic environments and maintain their psychological well-being (Kuiper, 2012). Resiliency is an ongoing process of coping, adapting, and managing life's stresses and hardships (Clark, 2009; Kuiper, 2012; Sharma, 2012). This ability to cope determines how a person reverts to normal functioning (Sharma, 2012). The next section explains how resiliency connects to the (1) the self of the therapist and (2) the supporting theoretical approach of the person of the therapist (POTT) model (Aponte, 1991; Aponte & Winter, 2000; Appel & Appel, 2008; Clark, 2009; Grosch & Olsen, 1994; McConaughy, 1987; Negash &

Sahin, 2011; Paris et al., 2006; Piercy et al., 1998; Shamai, 2005; Wolgien & Coady, 1997).

Self of the Therapist

The topic of the self of the therapist has become the focus of research on burnout (Aponte, 1991; Clark, 2009; Grosch & Olsen, 1994; Paris et al., 2006; Piercy et al., 1998; Wolgien & Coady, 1997). Though the research indicates that it takes an estimated 10 years for symptoms of burnout to become noticeable, the buildup significantly adds to the pressures of maintaining superior career performance and an adequate personal life (Appel & Appel, 2008; Batson, 1991; Grosch & Olsen, 1994).

Even though therapy is ultimately for the client's benefit, it is beneficial for everyone who is involved, including therapists (Aponte & Winter, 2000). In the therapeutic process, therapists extract clients' unspoken and spoken thoughts and feelings to relieve clients of insecurities, problems, and frustrations (McConaughty, 1987). This is done to gain a sense of perspective about unresolved personal issues (Aponte, 1991; Aponte & Winter, 2000; Negash & Sahin, 2011). In doing so, the self of the therapist becomes intertwined in what is referred to as the *wounded healer* dynamic, and countertransference sets in (Wolgien & Coady, 1997).

The concept of the wounded healer has received a great deal of theoretical consideration that shines light on therapists' interest in the profession (Wolgien & Coady, 1997). It is commonly said among therapists that many of them enter the profession because of their personal wounds. Therapists' original ability to heal their own wounds, to some degree, heightens their skills of empathy and insight, which they use to help their

clients. Research suggests that therapists are drawn to the profession because of turmoil or unsatisfied needs that stem from their families of origin (Wolgien & Coady, 1997).

According to Wolgien and Coady (1997):

A large scale empirical study that found that “therapists (psycho-analysts, psychiatrists, psychologists, and psychiatric social workers) came from families that were marked by social marginality, even though their family backgrounds did not seem different from other professional groups in terms of degree or type of family problems. (p. 22).

The authors concluded that there were a multitude of factors responsible for therapists’ career choices and highlighted that many therapists’ family backgrounds are no more problematic than the norm (Wolgien & Coady, 1997).

Wolgien and Coady (1997) suggest that therapists’ ability to help children is related to their confrontation and coping mechanisms related to their own childhood problems. There is a great deal of clinical opinion and some empirical support surrounding the idea that therapists’ effectiveness develops, in part, from their experiences coping with problems in their own lives. Though this issue needs to be further investigated, it generally represents the type of question that needs to be explored.

Shamai (2005) described the therapist’s work environment and concluded that the personal and professional intertwining of people’s lives interferes with their ability to balance both aspects of life. The lack of balance between work and family responsibilities leads to serious negative consequences that include higher stress levels, increased absenteeism, and lower productivity. Synthesis of personal and professional selves is necessary if therapists are to engage in healthy analysis of pre-existing issues that

influence their lives (Paris et al., 2006). From this self examination, therapists can uncover forgotten, unresolved issues connected to their own origins (Nagash & Sahin, 2011). This raises the question of how therapists, who might offer advice to clients about how to work through pre-existing family problems, have such difficulty addressing the same issues in their own lives (Grosch & Olsen, 1994).

Appel and Appel (2008) shed light on therapists' lack of awareness about their own challenges by describing a process that involves prioritizing roles involving family, work, and social relationships. Essentially, stress in one domain spills over into the other domains, often contributing to an increased overall level of distress. This triggers acute and chronic problems in one or more of their personal or work-related systems. Therapists' identities and levels of personal satisfaction suffer as the result of the stressful balancing act they undergo in efforts to manage their work and family responsibilities; this affects their ability make transitions between work and home. Struggling to cope with the chronic patterns of stress accumulation leaves therapists prone to burnout. It makes it difficult for them to address their overall stress level and differentiate between stress at work and stress at home.

Paris, Linville, and Rosen (2006) highlight the need for therapists to achieve balance in their study on the neglected topic of how therapists' personal and private lives function as creation of personal growth and how therapists take steps toward appreciating themselves. The researchers describe how significant events influence MFTs' personal and professional growth. They use the term *synthesis* to describe the integration of therapists' professional and personal selves, which creates a balance characterized by developmental and motivational awareness, self care, resiliency, and attention. Because

therapists' personal lives both directly and indirectly impact their work, the relational experiences they have with their families act as a basic training grounds for the therapy they practice. Therapists are able to generate an understanding of the systemic functioning of families, develop helping skills and communication skills, and adopt other tools that eventually help improve their level of differentiation and adaptation within their original family systems. Through this process of growth, therapists are able to attain emotional freedom in their clinical work by embracing their worldview. In general, the process of developing the self of the therapist involves the interplay of two factors: (1) countertransference and (2) double consciousness (Aponte, Powell, Brooks, Watson, Litzke, Lawless, and Johnson, 2009; Gabbard, 1999; Gabbard & Wilkinson, S. M., 1994; Guise, 2009; McConaughty, 1987; Negash & Sahin, 2011; Pearlman & Saakvitne, 1995; Protinsky & Coward, 2001).

Countertransference. Described as an intermediate phase in the process of developing the self of the therapist, countertransference becomes a blending of the polar extremes involving re-visitation of familiar, brutal, painful, and unresolved experiences in therapists' lives (Pearlman & Saakvitne, 1995). Countertransference is derived from therapists' conscious and unconscious reactions that run parallel to the interpersonal aspects of the therapeutic relationships they establish with their clients (Negash & Sahin, 2011; Pearlman & Saakvitne, 1995). The classic definition of countertransference is the recurrence of therapists' pathological and distorted transference, which causes them to lose sight of their clients' needs (Pearlman & Saakvitne, 1995). Therapists who fail to deal with their unresolved problems leave their clients feeling disrespected, unheard, overwhelmed, and alone.

A revised view of countertransference describes therapists as being more attuned and professionally accurate in dealing with clients' stories in context (Pearlman & Saakvitne, 1995). This occurs because therapists have the ability to filter their countertransference experiences through sophisticated therapeutic models, leading to real client experiences. They do this while maintaining intrapsychic independence from the clients' projected experience of supervision and personal therapy. The newer account of countertransference functions as a therapeutic instrument that serves as a catalyst for a therapeutic understanding of clients' experiences stirring beneath the surface of familiar unresolved issues (Pearlman & Saakvitne, 1995).

The in-the-moment experience shared between the therapist and client is symbolic of the intertwining, opposing forces of resistance and countertransference (Pearlman & Saakvitne, 1995). In addition, countertransference occurs because therapists bring their personal problems into the professional arena, which can lead to a combination of emotional exhaustion, unethical behavior, distractions during treatment, and an increase in critical and rejecting behavior toward clients (Guise, 2009; Negash & Sahin, 2011). During this intermediate phase, therapists recover from their countertransference by engaging in a variety of rudimentary efforts to help them work through the unresolved issues that were highlighted through countertransference (Pearlman & Saakvitne, 1995).

Double consciousness. According to Gabbard (1999), double consciousness allows therapists to simultaneously experience and observe therapy with their clients. It functions as a specific mindset that helps therapists delve into their clients' inner worlds while maintaining the capacity to reflect on what is happening and better understand their clients' therapeutic needs (Gabbard, 1999; Gabbard & Wilkinson, 1994; Protinsky &

Coward, 2001). When they are utilizing double consciousness, therapists are thinking their own thoughts, even as they are under the clients' influence, so to speak, in therapy (Gabbard, 1994).

To focus on their therapeutic relationships, therapists must examine their subjectivity and personhood by being mindful of their relational space and remaining aware of how their personal qualities shape their presence in therapy (Pearlman & Saakvitne, 1995). In doing so, they make therapy a two-way street in which the personal, spiritual, and cultural forces of the therapeutic conversation allow for a mutual metamorphosis by which both client and therapist can learn and influence each other's thought processes (Aponte et al., 2009; McConaughty, 1987). The dynamics of the therapeutic relationship develop from interpersonal interactions involving the actual process of therapy—represented by words, feelings, and behaviors—along with conscious and unconscious transference and countertransference responses relating to the assessment, interpretation, and examination of the complex relational context developed within the therapeutic relationship (Pearlman & Saakvitne, 1995). In essence, this relationship captures therapists' experiential reactions to therapy by enhancing their systemic awareness of the quality of mental health interventions and helping them maintain and appreciate a big picture perspective of the therapeutic experience (Aponte et al., 2009; McConaughty, 1987; Pearlman & Saakvitne, 1995; Protinsky & Coward, 2001).

Supporting Resiliency

In this section, the notion of resiliency is supported by the concepts of the person of the therapist model (POTT) and the attitude of a resilient therapist, which are further explained below.

The person of the therapist (POTT). The person of the therapist (POTT) model attempts to bridge the existing gap between therapists' personal and professional lives (Aponte, 1991). Instead of relying solely on professional training, the POTT model integrates both professional and personal training into therapy so as to fill in the gaps between therapists and their clients in terms of economics, status, race, education, experiences, lifestyles, and values (Aponte, 1991; Aponte & Carlsen, 2009). This model gives therapists the ability to explore various therapeutic approaches to facilitate a freer, more conscious and purposeful use of themselves within the therapeutic model of their choice (Aponte & Carlsen, 2009). Therapists are able to experience an inner conversation that allows them to connect and negotiate between their personal and professional selves. In doing so, therapists they are able to access their cultural philosophies about life and spiritual values to help them join with clients.

According to Irizarry (2009), POTT functions not as a theory or form of therapy, but rather as a method of conducting oneself as a therapist. The actual techniques employed by therapists are of lesser importance than the uniqueness of their personality and character. Therefore, therapists function as instruments that primarily influence the enterprise of therapy (McConnaughty, 1987).

The POTT model trains therapists to use themselves in therapy with the goal of developing a greater capacity for exchanges with clients in ways that further the therapeutic processes (Aponte & Carlsen, 2009). The goal of the model is to help

therapists take responsibility for their psychological issues and personal biases related to image, mortality, values, and philosophies. In the process, therapists learn to use what they master about themselves in an active constructive way in the moment with clients, gaining a better awareness of themselves and developing empathy for clients (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Lutz & Irizarry, 2009; McConaughy, 1987). The POTT approach acknowledges the moral components of the human journey, which include the pursuit of emotional growth and maturity, the adoption of sociocultural values, and the development of personal morality. It, therefore, bridges the gap between therapists' personal lives and the actual conduct of treatment (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000).

Like their clients, therapists walk into sessions with their own person struggles, scars, and battle wounds (Aponte & Winter, 2000; Negash & Sahin, 2011; Pearlman & Saavitne, 1995). As Aponte and Winter (2000) assert, "It is inevitable that therapists will evaluate and judge problems through the lens of their own world views, that they will naturally conjure up goals that fit with their ideals, and be inclined to propose solutions that fit in with their own views of life" (p. 136). Presenting themselves as interdependent people, therapists utilize their past experiences and perspectives to help them understand their clients' worldviews (Aponte, 1991). They must acknowledge and take ownership of the painful characteristics and behaviors that have occurred or are still occurring in their lives (McConaughy, 1987).

When therapists realize the connection between their personal and professional lives, they experience a paradigm shift that moves them from viewing their own issues as independent from their clients' to viewing their issues as avenues to foster more effective

connections with their clients (Lutz & Irizarry, 2009). In the process, therapists will begin to recognize that their signature themes are their personal challenges, which range from psychological and relational to cultural and spiritual issues, all of which function as powerful building blocks that shape the course of their lives as unique individuals. As challenging as this process is, Lutz and Irizzary (2009) encourage therapists to identify and explore their signature themes so that they will not affect their clinical work.

McConnaughty (1987) stresses the importance of therapists feeling solidly connected and comfortable with who they are. In the moment with clients, therapists can only utilize the techniques they have learned to enhance their work; but no matter how they try, they cannot duplicate the work of their teachers. According to McConnaughty, “Much of the theoretical literature emphasizes the need for the therapist to be a personally well- developed individual who is relatively comfortable with the vicissitudes of his or her character structure and who functions effectively in interpersonal relationships” (p. 304). By fully embracing who they are, therapists must have the capacity for intimate knowledge of themselves so that they will be able to admit to their own painful, personal characteristics or behaviors (McConnaughty, 1987).

Attitude of a resilient therapist. The attitude of a resilient therapist centers on the application of resiliency (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Clark, 2009; Hamel & Laraway, 2004; Kuiper, 2012; Protinsky & Coward, 2001; Rosenberg & Pace, 2006; Wolgien & Coady, 1997). However, the literature supporting this notion is somewhat limited. The majority of the research focuses on the qualities of a resilient therapist rather than the process of becoming a resilient therapist (Clark, 2009;

Hamel & Laraway, 2004; Kuiper, 2012; Rosenberg & Pace, 2006; Wolgien & Coady, 1997).

Resilient therapists are characterized as older, more experienced, and better able to create a positive work environment in which they manage stressors and remain energized (Hamel & Laraway, 2004; Clark, 2009; Rosenberg & Pace, 2006). Maturation and the accumulation of clinical experience give therapists the resiliency to establish and maintain clear boundaries, rely on the use of self, partake in enriching peer relationships, and resolve personal issues before they become problematic (Clark, 2009; Kuiper, 2012; Rosenberg & Pace, 2006; Wolgien & Coady, 1997). These therapists recognize and utilize all aspects of their life experiences in addition to their professional education and professional experience (Aponte, 1996; Buscaglia, 2009; Clark, 2009; Cluff & Bistock, 2001; Protinsky & Coward, 2001; Krueger & Powell, 1990; Wolgien & Coady, 1997). As such, they are less likely to behave uncertainly and more likely to use adversity to their advantage. They implement who they are into their work as therapists (Sharma, 2012).

As mentioned above, the existing literature on the process of becoming resilient is limited, but the literature that does exist describes the process as one of continuous growth, evolution, and awareness (Aponte, 1991; Burg, 1994; Clark, 2009; Rosenberg & Pace, 2006). Existing research emphasizes the need for therapists to trust and engage themselves as the means of integrating who they are into what they do in their professional practice of therapy, as well as in their personal lives to avoid burnout (Aponte & Carlsen, 2009; Buscaglia, 1978; Clark, 2009; Krueger & Powell, 1990; Lauderdale, 1982; Skovolt & Trotter-Mathison, 2011).

Within the existing literature on the subject, the attitude of the resilient therapist revolves around three key concepts: (1) sustained energy (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Berg, 1994; Berg & Dolan, 2001; Cluff & Binstock, 2001; Guise, 2009; Kruegar & Powell, 1999; Lipchik, 2002; Lutz & Irizarry, 2009; Maslach & Leiter, 1997; McConnaughty, 1987; Nelson & Thomas, 2007; Skovolt & Trotter-Mathison, 2011); (2) self-awareness (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Buscaglia, 2009; Clark, 2009; Krueger & Powell, 1990; Lutz & Irizarry, 2009; McConnaughty, 1987; Protinsky & Coward, 2001); and (3) mindfulness (Appel & Appel, 2008; Grosh & Olsen, 1994; Kilian, 2008; Leiter et al., 2001; Maslach, 1993; Maslach, 1982; Mathura & Sharma, 2014; Richards, Campienni, & Muse-Burke, 2010; Sharma, 2012).

Sustained energy. Focusing on the ability to stay energized and maintain an energy flow are the hallmark qualities of a resilient attitude (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Berg, 1994; Berg & Dolan, 2001; Cluff & Binstock, 2001; Guise, 2009; Kruegar & Powell, 1999; Lipchik, 2002; Lutz & Irizarry, 2009; Maslach & Leiter, 1997; McConnaughty, 1987; Nelson & Thomas, 2007; Skovolt & Trotter-Mathison, 2011). The attitudes of resilient therapists are related to the ways they make connections to experiences in their personal lives as a way to propel themselves in the direction of caring for others (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Cluff & Binstock, 2001; Guise, 2009; Kruegar & Powell, 1999; Lutz & Irizarry, 2009; Maslach & Leiter, 1997; McConnaughty, 1987; Skovolt & Trotter-Mathison, 2011).

Maslach and Leiter (1997) explain that most therapists initially feel alive in their work, reflecting hopefulness, inspiration, and engagement through their interactions with clients. They are excited, enriched, self-motivated and eager to take on challenges, dedicating time and energy to work through obstacles, gaining feedback from co-workers, and experiencing pride and passion while doing their jobs. For new therapists, “the enjoyment of successes can balance out the pain of failure, whether the successes are big achievements or small everyday expressions of appreciation from others” (Maslach & Leiter, 1997, p. 28). This creates cyclical pattern in which therapists’ positive emotions and feelings influence their commitment and motivation, thereby encouraging them to feel valued and appreciated (Maslach, & Leiter, 1997).

According to Osborn (2004), one of the defining qualities resilient therapists acquire with time is stamina. She defines resiliency as the endurance and strength to withstand or hold up under pressure and explains, “stamina represents a salutary of non-pathological orientation and is selected as an alternative to the deficit or pathological perspective suggested by the terms burnout prevention and coping” (Osborn, 2004, p. 314). Stamina includes a variety of characteristics such as persistence, confidence, and enthusiasm for work and for coping with challenging lifestyle circumstances (Osborn, 2004). Internal stamina is defined as having a sense of mastery, personal control, and optimism in the course of difficult times. Representing a dynamic life force, stamina allows for therapists to focus their attention on how they can cultivate, amplify, and use their strengths and resources as a means of energetically moving forward toward growth, productivity, and health.

To achieve stamina, Osborn (2004) recommends that therapists consider the acronym STAMINA: selectivity, temporal sensitivity, accountability, measurement and management, inquisitiveness, negotiation, and acknowledgement of agency. Selectivity involves therapists being aware of how they present and position themselves in their professional expertise. Temporal sensitivity “implies that time is not only something to be managed and manipulated well (e.g., working within deadlines, arriving to and ending counseling sessions on time), but also something that is viewed realistically and respectfully” (Osborn, 2004, p. 322). Accountability refers to respecting and working within professional guidelines, upholding ethical standards, and explaining and defining consistent practice in regards to theory and research. The measurement and management ingredient stipulates that therapists make careful and ongoing efforts to conserve and protect valuable resources such as objects (e.g., certificates and awards), conditions (e.g., rewarding work and quality intimate relationships), personal characteristics (e.g., hopefulness, assertiveness, and leadership skills), and energies (e.g., income and specialized knowledge). Inquisitiveness is characterized as having a sense of wonder and curiosity. Negotiation is understood to occur when therapists utilize their ability to be flexible and not give in during the give and take process of therapeutic discussions. Finally, the acknowledgement of agency implies that therapists are able to utilize their resources to get positive outcomes at work.

Appel and Appel (2008) discuss the multi-systemic assessment of stress and health (MASH) model, which is a family system framework that re-conceptualizes the mechanisms of stress and coping at work. Its revision was based on comprehensive bio-psychosocial system models of stress and health along with earlier models of family

stress, functioning, and adaptation. Viewing individuals' stress and coping resources as originating from systemic life domains, the MASH model assesses the four levels of a person's health: personal, couple, family, and work (Appel & Appel, 2008). It integrates earlier models of family stress, coping, and adaptation to view individuals' stress and coping resources deriving from multiple life systemic domains. Organized in relationship coping and skill coping dimensions, the relationship coping dimension focuses on the two constructs of cohesion (i.e., the amount of emotional bonding in the system) and flexibility (i.e., the degree to which the system changes its roles and rules in the course of time). The skill coping dimension, on the other hand, encompasses constructs of problem-solving and communication skills. The act of problem-solving becomes a positive and active process of directly dealing with problems by making positive changes to resolve them. Communications, however, function as effective exchanges of information (Appel & Appel, 2008).

The MASH model increases therapists' adaptation and life satisfaction; it helps them increase their coping resources and better manage stress (Appel & Appel, 2008). According to the findings of research on the model, family system resources may be key factors in predicting whether therapists will become vulnerable to burnout. These findings indicate that social support from home could be key in alleviating the burnout symptoms. Appel and Appel (2008) found that relationship resources are critical to healthy adaptation, which stems from healthy family relationships marked by family members' ability to bond emotionally and adapt to stress by altering the rules and roles within the family system. Both relationship-coping resources and skill coping resources appear to predict adaptation or adjustment in the work setting. Coping skills can be

replicated across systems and, at the same time, are used to differentiate between those employees who are suffering from burnout and those who are not.

Highlighting the importance of staying energized, Shirom (2003) explains how vigor helps therapists maintain their motivation to work with challenging clientele. Vigor is defined as an emotion representative of innate patterns of responses to environmental cues that evolves because of its general functional significance. According to Shirom, it is a positive affective response that therapists experience in response to their ongoing interactions with significant elements in their jobs and work environments. It is comprised of the interconnected components of physical strength, emotional energy, and cognitive liveliness. Vigor can be seen as the combination of motivational aspects with elements of resiliency, which allow therapists to maintain high levels of positivity and well-being in the face of significant adversity (Davidson, 2000; Shirom, 2003).

Expanding on his conceptualization of vigor, Shirom (2003) explains that Hobfoll's Conservation of Resources (COR) Theory functions as its central tenant. The COR model serves as a basic means for therapists to obtain, retain, and protect that which they value: resources (Davidson, 2000; Shirom, 2003). The concept of vigor relates to energetic resources such as physical, emotional, and cognitive energies (Shirom, 2003); therefore, it can be used to describe how therapists feel and think about their workplace and their jobs during vulnerable times when they are stressed and burnt out. The argument can be made that feeling vigorous may be an adaptive method of coping with reoccurring losses as a means of accomplishing work and receiving potential rewards and additional resources. Vigor is associated with positive feelings and a sense of accomplishment; it can inspire creativity and influence others (Shirom, 2003).

Self-awareness. The second element of the attitude of a resilient therapist is self-awareness (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Buscaglia, 2009; Clark, 2009; Krueger & Powell, 1990; Lutz & Irizarry, 2009; McConaughty, 1987; Protinsky & Coward, 2001). Hamel and Laraway (2004) point out that successes in therapy are dependent on both controlled and uncontrolled factors. Therapists have to rely on self-awareness most of the time when working with clients as a means of stamping their work with passion and self-respect (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Buscaglia, 1978; Clark, 2009; Guise, 2009; Krueger & Powell, 1990; Lutz & Irizarry, 2009; Maslach & Leiter, 1997; McConaughty, 1987; Protinsky & Coward, 2001).

McConaughty (1987) defines self-awareness as a process by which therapists give themselves permission to experience their inner thoughts and feelings, leading them to a deeper understanding of themselves in the therapeutic process. Maslach and Leiter (1997) view self-awareness as an inner gauge through which therapists recognize obscurities related to personal anxieties and discomfort related to job roles. By acknowledging their inner feelings, therapists create a means of helping themselves become more helpful to their clients (Maslach & Leiter, 1997; McConaughty, 1987; Protinsky & Coward, 2001; Richards et al., 2010). By being more in touch with their inner selves, therapists can develop a clearer understanding of their capacity to care for their clients; they can also increase their self-awareness in the management of their trauma client caseloads (McConaughty, 1987; Protinsky & Coward, 2001; Richards et al., 2010). As therapists become more trusting of themselves, they gain confidence in knowing that they are strong and will remain so as they allow for the unconscious

reactions to their clients that arise (McConaughy, 1987; Protinsky & Coward, 2001; Richards et al., 2010).

Killian (2008) recommends that training programs facilitate the concepts of self-awareness and self of the therapist as important elements of their programs. He emphasizes that therapists can better manage their emotional states so as to decrease their chances of developing burnout. In the process, they become educated about the importance of their self-awareness and how they can implement more of what works for them and less of what does not work (Berg, 1994; Grosh & Olsen, 1994; Hamel & Laraway, 2004; Killian, 2008). By making the necessary adjustments in their lives, therapists can limit their stress and chances of development of burnout (Berg, 1994; Grosh & Olsen, 1994; Hamel & Laraway, 2004; Killian, 2008; Maslach, 1982; Maslach & Leirter, 1997).

Yan and Wong (2005) discuss self-awareness within the the context of social worker, explaining that it produces a subject-object dichotomy in the worker-client relationship. In this dichotomy, social workers are viewed as subjects capable of becoming neutral, culture-free agents; clients are seen as objects who stay within the limits of their culture. Social workers' awareness, like awareness among MFT and MHC counterparts, is centered on cultural identification inclusive of traditional understanding as well as cultural biases, rules, and beliefs. Culture assumes both social control and integrative functioning of passing messages from one generation to the next. People construct their beliefs about certain behavior based on cultural perspectives that they have about the rhythm and patterns of life.

When working with clients of different cultures, social workers view their clients subjectively, deriving their explanations from various sources of information—including personal experiences—which allows them to reflect on their own cultural views (Yan & Wong, 2005). Competent social workers should analyze and maintain high levels of awareness of their own cultural background to prevent their own cultural values, biases, preconceived notions, and personal limitations from creeping into their work. According to Yan and Wong (2005), cultural competence acts as the foundation of an effective cross-cultural social work relationship. Thus, awareness functions as a pre-integrative processing activity through which therapists examine their own culture and their perception of their clients' cultures. Self awareness is also considered a post-integrative activity because of the need for ongoing inductive learning.

Yan and Wong (2005) identify three approaches to self awareness that are reflective of specific epistemological positions and conceptualizations of self. In the first approach, *conscious awareness*, social workers are awakened to experiences by focusing their awareness on the experiences themselves, rather than on the self who is having the experience. The second approach is *reflective awareness of the self*, which describes the self-behavior, effect, and cognitive content as becoming the objects of reflection. The third approach is *reflective awareness*, which allows the use of self in a reflective manner that is self-referential. In some sense, any assessment of the self that is based on self-awareness is made by the same self who is being assessed; this allows recognition of the self who is reflecting and the self who is being reflected to reside in the same social and historical space.

The reflexive approach posits that self-knowledge is attained by reducing the distance between the knowing and the known. Valid self-knowledge is possible because people are not strangers to the self (Richards et al., 2010; Yin & Wong, 2005). The self is viewed as a configuration of many selves that make up a person instead of one private isolated entity (Yan & Wong, 2005). The self is incomplete, because it does not have the other person or persons to contextualize personal experiences. Self-reflexivity then becomes a dialogic process in which self and other co-author interpersonal conversations. Thus, the goal of self-reflection is to promote reflexive awareness of working with oneself in creating new strategic possibilities for relationships while simultaneously searching for new possible discursive opportunities of interacting with the other (Yan & Wong, 2005).

Mindfulness. The last and most crucial element of a resilient attitude is mindfulness (Appel & Appel, 2008; Grosh & Olsen, 1994; Kilian, 2008; Leiter et al., 2001; Maslach, 1982, 1993; Mathura & Sharma, 2014; Richards et al., 2010; Sharma, 2012). Mindfulness has only been recently introduced in Western culture; as such, uncertainty revolves around formulating an exact definition (Richards et al., 2010). The origins of mindfulness come from Buddhist traditions and have been used to refer to a psychological state of awareness that is based on self-awareness and full presence of the mind, emotions, creativity, soulfulness, and spirit (Mathura & Sharma, 2014). According to Mathura and Sharma (2014):

Mindfulness refers to the psychological quality that involves bringing one's complete attention to the present experience on a moment-to moment basis, or involves a kind of non-elaborative, non-judgmental, present-centered awareness

in which each thought, feeling, or sensation that arises in the attention field is acknowledged and accepted as it is. (p. 535)

To be mindful means to maintain an in-the-moment awareness of one's thoughts, feelings, and bodily sensations in surrounding environments while accepting them without judgment (Mathura & Sharma, 2014; Sharma, 2012).

Mindfulness has been found to directly affect well-being and has been considered to be the missing link between self-awareness and well-being (Richards et al., 2010). To help therapists differentiate between their stuff and clients' stuff and reduce stress buildup, research points to self-care methods as being viable means of alleviating stress and preventing burnout from developing (Appel & Appel, 2008; Grosh & Olsen, 1994; Kilian, 2008; Leiter et al., 2001; Maslach, 1982, 1993). Research has found direct links connecting self-care with both self-awareness and well-being (Richards et al., 2010). Because of their susceptibility to burnout, which can affect their clinical work, it is imperative for therapists to engage in self-care (Corey et al., 1998; Edward & Patterson, 2006; Fontes et al., 1998; Guise, 2009; Hamel & Laraway, 2004; Killian, 2008; Richards et al., 2010).

Mindfulness has been used as intervention for treating physical ailments. It has been structured into formal interventions, such as Mindfulness Based Stress Reduction (MBSR) (Richards et al., 2010), which allows clients to develop an understanding of the self and, ultimately, an ability to regulate the self using techniques that allow them to notice, accept, and regulate their emotions and thoughts (Richards et al., 2010). It has been found to be successful in reducing stress and relieving medical illness, psychological distress, and physical and emotional pain.

Well-being and mindfulness have been theoretically and empirically associated with one another (Mathura & Sharma, 2014; Sharma, 2012). The elements of awareness and nonjudgment within the concept of mindfulness are regarded as antidotes against psychological distress rumination, anxiety, worry, fear, anger, and other maladaptive tendencies associated with avoiding, suppressing, and obsessing over distressing thoughts and emotions (Mathura & Sharma, 2014). In general mindfulness functions as a good predictor of well-being. As such, I will discuss it in the context of self-care and well-being (Negash & Sahin, 2011; Mathura & Sharma, 2014; Richards et al., 2010; Sharma, 2012).

Self-care. The general theme of self-care includes the physical, psychological, spiritual, and support components (Negash & Sahin, 2011; Richards et al., 2010;). The physical dimension of self-care includes incorporation of physical activities resulting in bodily movements and energy utilization (Richards et al., 2010). Activities such as exercise, sports, household activities, and daily functioning all fall under this category (Negash & Sahin, 2011; Richards et al., 2010). Other aspects of a healthy lifestyle, like proper nutrition and sleep awareness, are also included in this category of self-care (Negash & Sahin, 2011).

Promoting exercise as an essential ingredient for well-being, Negash and Sahin (2011) and Killian (2008) explain that maintaining physical health, making time for spiritual practices, taking part in meditation, and journaling are important ways that family therapists can maintain emotional stability. The intensity of physical activity and the amount of time spent on it can vary dramatically from one person to the next (Negash & Sahin, 2011; Richards et al., 2010). The U.S. Department of Agriculture (2005)

recommends that people engage in at least 30 minutes of physical activity most days of the week to receive the benefits (Richards et al., 2010). Physical activities also provide general wellness benefits, such as decreases in symptoms of anxiety and depression and increases in quality of life factors associated with coping.

In addition to exercising regularly, therapist should focus on addressing their nutrition and sleep awareness. Sleep patterns and insufficient exercise are associated with physical and emotional reactions. It is important that therapists attend to these issues, as trouble sleeping, amplified physical reflex, increased emotional reactivity, hypervigilance, and diminished interest in regular activities are all common signs of burnout (Negash & Sahin, 2011).

Because therapists spend the majority of their time providing services to clients, it is suggested that they themselves receive both personal and professional support (Leiter et al., 2001; Negash & Sahin, 2011; Paris et al., 2006; Skovholt & Trotter-Mathison, 2011). Psychological self-care involves therapists getting personal therapy to better manage stressful circumstances that impair their work performance (Leiter et al., 2001; Negash & Sahin, 2011; Paris et al., 2006; Richards et al., 2010; Skovholt & Trotter-Mathison, 2011). Research shows that supervision acts as an opportunity for therapists to explore their cases while at the same time realizing the personal connections they have with their work (Paris et al., 2006). Because empathy requires understanding of another person, therapists' personal connections can cloud their lens to the point that they experience difficulties functioning therapeutically (Richards et al., 2010). Therapy becomes a viable option for therapists to work through and settle unresolved personal issues that infringe on how they position and view themselves personally in relation to

what they do professionally (Leiter et al., 2001; Negash & Sahin, 2011; Paris et al., 2006; Skovholt & Trotter-Mathison, 2011). It has been estimated that about “68.9% of AAMFT Clinician Members who had participated in personal therapy reported their experiences as very successful, with 95% of the respondents reporting at least some success in therapy” (Negash & Sahin, 2011, p. 10). Personal therapy has been shown to enhance therapists’ empathizing skills to the extent they become more self-aware in both their professional and personal lives (Richards et al., 2010).

Another dimension of self-care known as spiritual self-care is loosely defined as being geared towards describing the meaning and understanding of life (McCollum & Gehart, 2010; Negash & Sahin, 2011; Richards et al., 2010). Spiritual behaviors such as meditation, yoga, and keeping a personal journal have been found to aid in coping with burnout (Negash & Sahin, 2011; Richards et al., 2010;). McCollum and Gehart (2010) suggest that therapists practice meditation to center themselves in the present moment by channeling their feelings, thoughts, and attention, and utilizing their curiosity, acceptance, and investigation to focus on clients’ current circumstances in therapy. A regimen of yoga can facilitate enhanced methods for self-awareness, patterns of cognition, and lifestyles that are beneficial to therapists’ professional and personal goals (Negash & Sahin, 2011).

Finally, the support component of self-care includes both professional and personal support systems (Corey et al., 1998; Edward & Patterson, 2006; Fontes et al., 1998; Guise, 2009; Hamel & Laraway, 2004; Killian, 2008; Richards et al., 2010). Through professional self-care methods such as formal supervision, case staffings, and peer reviews, therapists are able to vent their frustrations and struggles with their clients

while gaining perspective about new directions they can take with them in therapy (Killian, 2008; Tosone, Muttman-Shwartz, & Stephens, 2012). Supervision functions as a means for therapists to explore their pain and disturbing countertransference emotions regarding client interactions (Tosone et al., 2012). During peer review conversations with co-workers, friends, and family members, therapists talk about their cases without delving into too much details and maintaining clients' confidentiality (Guise, 2009; Killian, 2008). The accumulated advice and feedback provide therapists with constructive critiques of their work while shedding light on new avenues they can venture into with clients to help them reach their treatment goals faster. It also helps them work through any ethical and clinical difficulties (Edward & Patterson, 2006; Guise, 2009; Hamel & Laraway, 2004; Killian, 2008; Maslach, 1982; Richards et al., 2010; Skovholt & Trotter-Mathison, 2011). In addition to this, spending time, laughing, and having fun with friends can help therapists avoid stress buildup and prevent the tiring effects of burnout (Negash & Sahin, 2011; Paris et al., 2006).

Well-being. Research on well-being is rapidly expanding, bringing attention to the holistic, dynamic state of understanding peoples' lives in psychological and socio-cultural contexts (Mathura & Sharma, 2014; Sharma, 2012). Defined as a state of serenity and inner happiness, well-being is the condition of being healthy, successful, and contented (Mathura & Sharma, 2014). Well-being centers on peoples' abilities to develop potential, work productivity, and creativity in building strong relationships with others in their personal and professional lives. The state of contentment is accomplished by the successful integration of physical, social-emotional, and cognitive functions. Well-being

enhances a person's ability to rise above moderate psychological and environmental problems as a means of establishing healthy relationships (Mathura & Sharma, 2014).

Relating to the aspects of peoples' lives that they value as important, well-being moves away from what one seems to equate with happiness and supports correlations with mindful practices and wisdom (Mathura & Sharma, 2014). According to Sharma (2012), "The World Health Organization (1964) defines health as a state of 'complete physical, mental and social well-being, and not merely the absence of disease or infirmity'" (p. 440). Living healthily is inclusive of the natural laws pertaining to the body, mind, and environment; thus, well-being can be divided into psychological well-being and physical well-being (Sharma, 2012).

Well-being functions as a wide-ranging concept that embraces the effects of everyday experiences (Sharma, 2012). Easily accessible through self-reporting, general well-being is considered to be a subjective state of being in harmony with the physical, social, psychological and spiritual aspects of people being content with their environmental conditions. Feeling contentment, happiness, and satisfaction in one's life are indicative of general wellness and high resiliency to stress. Therefore, attaining a harmonious balance among all these aspects is necessity for therapists to experience resiliency to stress (Sharma 2012).

Need for therapists' own voice. In my review of the literature, I noticed that no studies have been conducted to explore the lived experiences of successful community-based, entry level MFT therapists during their early years of practice (Acker, 2004; Appel & Appel, 2008; Clark, 2009; Cluff & Binstock, 2001; Davis, 2013; Greenson et al., 2009; Gupta, Peterson, Lysaght, & Zweck, 2012; McConnaughty, 1987; Paris et al., 2006;

Protinsky & Coward, 2001; Wolgast & Coady, 1997). The purpose of this study is to explore what works for successful in-home family therapists working at community-based agencies.

CHAPTER III: METHODOLOGY

I implemented a qualitative research design to explore what works for successful in-home family therapists working at community based agencies. By utilizing a qualitative research design, I was able to gather a more in-depth exploration of participants' experiences and understanding. In the process, I explored the natural settings in which the participants experienced the phenomenon under study and captured how they make sense of and interpret it (Creswell, 2007). Highlighting situational contexts, qualitative research sheds light on the political, social, and cultural characteristics involved in the study. Researchers, participants, and readers become holistically engaged in qualitative research because it magnifies the complexities and details of the issues being studied. Due to this collaborative dynamic, qualitative research designs become an empowering experience for not only the participants, but the researchers and readers as well (Creswell, 2007).

Phenomenology

The qualitative research design I incorporated in this study is the phenomenological approach (van Manen, 1990; van Manen, 2011; Laverly, 2003; Kafle, 2011; Creswell, 2007; Reiners, 2012; Williamson, 2005). The aim of phenomenological research is to describe everyday experiences through the perspectives of the people who live them (Finlay, 2011). The uniqueness of individuals' experiences allow for insight and understanding about the human condition and exploration of the personal and professional aspects of development and life to be explored. Acting as a transformative opportunity for both participant and researcher, phenomenological research offers individuals the ability to bear witness to their own experience and be given opportunities

to voice what they are going through so as to make sense of the situation in focus. For the purposes of this study, I restricted the historical origins of phenomenology—which I explain in the next sessions—to the famous works of the following classical phenomenologists: Husserl and Heidegger (Kafle, 2011; Lavery, 2003; Reiners, 2012; van Manen, 1990, 2011; Williamson, 2005; Winter, 2013).

Husserl

The origins of phenomenology can be traced back to a German mathematician named Edmund Husserl (Creswell, 2007; Kafle, 2011; Lavery, 2003; Reiners, 2012; van Manen, 1990, 2011). Known as the father of phenomenology, Husserl developed descriptive phenomenology, which is also known as transcendental phenomenology (Kafle, 2011; Lavery, 2003; Reiners, 2012; Williamson, 2005). Husserl believed that phenomenology suspended all suppositions, was related to consciousness, and was based on the meaning of individual experience. He asserted that philosophy takes into account the position of conscious recognition involved in human perception of objective reality (Lavery, 2003; Williamson, 2005; Winter, 2013). Husserl viewed the structure of consciousness as a means of delving through the depths of reality to uncover the true meaning of experiences (Becvar & Becvar, 1998; Lavery, 2003; Reiners, 2012). Within this context, life experience is defined as what people experience pre-reflectively, without taking things for granted, and without categorizing or conceptualizing things (Lavery, 2003). Husserl stressed that descriptive phenomenology, which is comprised of both objective and subjective qualities, captures the meaning of the human experience as it is lived (Creswell, 2007; Kafle, 2011; Lavery, 2003).

Defining phenomenology as a rigorous science, Husserl created an approach comprised of three steps: Anschannng, intentionality, and bracketing (Creswell, 2007; Finlay, 2011; Kafle, 2011; Lavery, 2003; Williamson, 2005). Anschannng refers to the phenomenological institution involving imagination; it involves looking at the phenomenon with open eyes of wonder, empty of all preconceived ideas and theories (Williamson, 2005). Intentionality is defined as the amalgamation of experiences of perception, thought, memory, imagination, and emotion that together address the existence of material reality against a positivistic background in a manner that allows for inter-subjectivity to occur (Finlay, 2011; Kafle, 2011; Lavery, 2003; Manen, 1990; Reiners, 2012; Williamson, 2005). Finally, bracketing is a term Husserl derived through mathematical connections to explain the reduction process of holding back pre-conceived and pre-learned feelings, traditions, beliefs, and ideas to avoid making biased judgments (Finlay, 2011; Lavery, 2003; Williamson, 2005).

Heidegger

Expanding on Husserl's views of phenomenology, Heidegger initiated the hermeneutic phenomenological movement by emphasizing that phenomenology needs to be representative of people's descriptions of what it is to be human (Lavery, 2003). Heidegger described his version of the hermeneutical phenomenology cycle as being comprised of understanding, pre-understanding, and interpretation (Kafle, 2011; Lavery, 2003).

The primary distinction between phenomenology and hermeneutic phenomenology is that Husserl concentrated on understanding beings or phenomena, whereas Heidegger focused on *Dasein*, which refers to the mode of being human

(Lavery, 2003). Heidegger's perspective of human beings was that they are primarily concerned creatures; he placed an emphasis on their fate in what he described as an alien world. Heidegger proposed a view of consciousness as something that is not separate from the world but informed by historically lived experiences. According to Lavery (2003), "He believed that understanding is a basic form of human existence in that understanding is not a way we know the world, but rather the way we are" (p. 8). Equating historicity to the basic building block of understanding, Heidegger highlighted that for this to be possible, one's background cannot be seen as completely explicit; instead, the view of people and the world is indissolubly related to culture, social, and historical contexts (Lavery, 2003).

According to Heidegger, pre-understanding is the structure of the world (Lavery, 2003). Viewed as already being with us, pre-understandings function as a reference of experiences that people resort to understanding their background conceptualizations. Pre-understandings are culture-based; they are formulated before we understand what they are, and they become part of our historicity of background. As Lavery (2003) explains, "Meaning is found as we are constructed by the world while at the same time we are constructing this world from our own background and experiences" (p. 8). As such, there is an interrelated and interrelational transaction that occurs between people and the world as they constitute and are constituted by each other (Lavery, 2003).

Out of pre-understanding comes the next part of understanding: interpretation (Lavery, 2003). According to Lavery (2003), "Annells (1996) reviewed hermeneutics as an interpretive process that sought to bring understanding and disclosure of phenomenon through language more over, hermeneutics is the study of human, cultural activities as

texts with a view towards interpretation to find intended or expressed meanings” (p. 9). Referring to written and verbal communications as well as the visual arts and music, Heidegger further stated that all understandings are interconnected to a given set of structures inclusive of historicalities that cannot be eliminated; therefore, people need to be aware as possible to account for their interpretive influences (Lavery, 2003).

In-Depth Interviewing Process

In phenomenological research studies, the process of interviewing participants functions as an essential part of gaining an understanding of the human experience. Seidman (1998) describes interviews as the means through which people’s stories can be known. He stresses the importance of thinking about the details that people select to relate their experiences, explaining that “it is this process of selecting constitutive details of experience, reflecting on them, giving them order, and thereby making sense of them that makes telling stories a meaning-making experience” (p. 1). Each word of people’s stories represents a microcosm of their consciousness, allowing more complicated stories and educational issues to become accessible.

In-depth interviews allow researchers to explore interests in understanding the experiences of others and the meanings they attach to them (Seidman, 1998). By viewing people’s stories as valuable, interviewers can assume a neutral stance and remain open-minded about their participants’ experiences. The acquisition of a perfect understanding is never possible, since interviewers cannot enter participants’ streams of consciousness. Because interviewers cannot be their participants, they are forced to rely on their observations during the in-depth interviewing process.

Interviewing involves a method of research that sheds light on two categories that center around the significance of language and the inquiry of human beings (Seidman, 1998). Allowing participants to express what it means to them to be human, language serves as a way of capturing the symbolic representation of experience while highlighting the necessity of the communication. The process of interviewing is an original form of inquiry through which transcribed narratives shed light on the essence of making sense of people's human experiences.

Examining the context of people's behaviors, interviewers are able to understand the meaning behind those behaviors (Seidman, 1998). As Seidman (1998) points out, "A basic assumption in in-depth interviewing research is that the meaning people make of their experience affects the way they carry out that experience" (p. 4). The process of interviewing allows interviewers to go beyond the realm of observation by understanding participants' actions through the contexts of their behaviors.

Study Methods

Given that the aim of this study was to explore the lived experiences of successful therapists in community-based agencies, I solicited the participation of six therapists working in community agencies for a one-hour interview at a neutral location, such as a local library study room. I structured the interview questions based on SFBT exception questions geared specifically toward capturing detailed descriptions of participants' lived experiences (Nelson & Thomas, 2007). By highlighting positive exceptions, these questions called attention to the useful events and behaviors in the participants' lived experiences.

Participant Selection

To be considered for this study, participants must have had (a) a master's degree in family therapy, (b) one or more years of experience working as an in-home therapist at a community-based agency, (c) a current position at a community-based agency with successful performance, and (d) willingness to provide a diverse, rich, and unique description of their successful experiences. In addition to this, participants must have agreed to my using a recording device to gather the audio content during the interview.

I recruited participants by posting an advertisement on my personal Facebook page. I also sent a mass email explaining the study. In addition to this, I contacted agency directors requesting recommendations for in-home community-based therapists who might be interested in participating. I found these agency directors through referrals I received from my peers and dissertation Chair. A snowballing process occurred, as therapists who agreed to participate in the study recommended other therapists. This process continued until I obtained a total of six participants.

The community-based agency therapists I included in the study all worked in an agency in a position involving home visits for at least a year; they all reported being reasonably satisfied with their jobs and were all described by their agencies' clinical directors as being in good standing. I gave preference to therapists who met those criteria and had also won awards or otherwise been recognized for their exemplary work.

Initial Contact

During my initial contact with each potential participant, I explained that my aim was to recruit six therapists willing to participate in a one-hour interview centered on their experiences as successful community-based therapists. I explained that the

interviews would take place at a neutral location that chosen based on their convenience. I informed the potential participants that on the day of their scheduled interview, I would provide them with an introductory iacket consisting of an introductory letter, a confidentiality packet, a handout on the potential side effects of participating, and the formal Informed Consent document (See Appendix A). The introductory packet explain the specifics of confidentiality and participant treatment pertaining to researcher-participant interactions throughout the course of the study.

During my initial contact with potential participants, I inquired about and recorded their highest educational degree, number of years of experience in a community-based agency, and professional titles held in community-based agencies. I then proceeded to fill out a three-column contact sheet comprised of participants' names, contact numbers, and e-mail addresses (See Appendix B). At the end of my phone conversation with the participants, I informed them that I would call two days prior to our scheduled interview to confirm. I concluded by humbly thanking them for their corporation and participation.

Interview Process

I met with each of the participants at a neutral location, such as a local library study room, to conduct the interviews. I started the interviews by thanking participants for their attendance and then proceeded to briefly describe the purpose of the study and explain that the interview would be an open discussion on the topic of what works for successful in-home family therapists working at community-based agencies. Next, I distributed and explained each section of the introductory packet consisting of the following forms: (a) confidentiality forms, (b) consent forms, (c) signature of agreement

for participation forms, and (d) time availability and pseudonym forms (See Appendix A). While explaining each section of these forms, I instructed participants to sign and initial in certain portions of the packet to conserve time.

After each participant completed the forms, I began the interview by asking the following questions:

1. What, if anything, do you find rewarding about doing community-based therapy?
2. What, if anything, challenges you about community-based therapy?
3. Do you feel you have avoided burnout, and if so, what has worked for you?

My intention was to involve myself in the dialogue to gather information about the participants' resiliency. I used an audio recorder to capture the interview dialogues.

Data Analysis

I analyzed the data from the interviews using thematic analysis. Known as the simplest form of categorizing data, thematic analysis calls for researchers to review the data, make notes, and then sort those notes into categories (Harvard University, 2008; Finlay, 2011). Thematic analysis focused on identifying themes and patterns of behavior in people's lives (Aronson, 1994; Harvard, 2008; Finlay, 2011). This form of analysis was appropriate for this study, because this analysis goes beyond explicit wording and phrases and focuses on also identifying implicit themes (Aronson, 1994; Finlay, 2011; Guest, 2012; Harvard, 2008).

The first step in the process involved transcribing the audio recordings of my interviews with participants (Aronson, 1994). I was then able to discern patterns of

experiences based on the conversations, selecting direct quotes and paraphrasing common ideas (Aronson, 1994).

With great attention to detail, I reduced the data through the process of coding, assigning codes based on the research question, salient interests that arose in the interviews, and recurrent issues (Aronson, 1994; Attride-Stirling, 2001). As Attride-Stirling (2001) explains, “In this step the codes are applied to the textual data to dissect it into text segments: meaningful and manageable chunks of text such as passages, quotations, single words, or other criteria judged necessary for a particular analysis” (p. 391). The codes I generated through this process had explicit boundaries and could not be used interchangeably, allowing me to focus on analyzing a specific object (Attride-Stirling, 2001).

Related patterns were placed with corresponding patterns (Aronson, 1994). As Guest (2012) explains, “Codes are typically developed to represent the identified themes and applied or linked to raw data as summary markers for later analysis” (p. 10). Maintaining reliability is of great concern in thematic analysis, because this kind of analysis relies heavily on interpretation of codes and application of codes to chunks of data (Guest, 2012).

The next step of analysis involved combining and cataloging related patterns into sub-themes (Aronson, 1994; Attride-Stirling, 2001). According to Aronson (1994), “Themes are identified as units derived from patterns such as ‘conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs’” (p. 1). The themes I generated brought together components of ideas from the participants’ stories, providing a comprehensive picture of their collected experiences making it easier

to see patterns emerge (Aronson, 1994). As such, it is recommended that researchers seek feedback during and after their review of the transcripts (Aronson, 1994).

The last step of analysis was to formulate my rationale for choosing each theme (Aronson, 1994; Attride-Stirling, 2001). I gathered connected supportive inferences regarding sessions to the literature (Aronson, 1994; Attride-Stirling, 2001). Once I created themes and studied the existing literature, I formulated theme statements to develop a storyline that interwove the literature and the findings from my study (Aronson, 1994; Attride-Stirling, 2001).

Thematic analysis was a flexible process that allowed me to maneuver thematic data in the direction that the analysis process took me (Harvard, 2008). Using thematic analysis allowed for a closer analysis of the data and fostered a deeper appreciation of the content. I was able to look for broader patterns in participants' responses in order to conduct a more finely grained analysis (Harvard, 2008).

CHAPTER IV: DATA ANALYSIS AND PRESENTATION

The purpose of this study was to discover what works for successful in-home family therapists working at community-based agencies. Through word of mouth and emails sent to my colleagues at Nova Southeastern University (See Appendix C for Research Advertisement), I recruited six participants for the study. Once I made initial contact with the participants, I scheduled the interview appointments by phone with each of the six participants. We arranged for the interviews to take place at neutral locations that were both convenient for the participants and conducive for a one-hour audio recorded interview. Interviews took place in an available conference room located at participants' community-based agencies. At the start of each of the six interviews, I presented the participants with an Introductory Packet and asked three open-ended questions focusing on the rewards and challenges of in-home work and methods of avoiding burnout.

Participants' Demographics

The participants in this study were two men and four women. All six participants met the study requirements of (a) having a master's degree in family therapy, (b) being employed as an in-home therapist for one or more years at community-based agencies, and (c) having successful performance at their current employment at community-based agencies located in the greater Fort Lauderdale area. In the following section, I will introduce each participant, explaining their demographic information and their perspectives on what has worked for each of them in their successful careers as in-home therapists working in community-based settings.

Barbra

Barbra is a 40-year-old, single woman of Irish background. She has a Ph.D. in Family Therapy and a master's degree in Mental Health Counseling (Barbra, 2). At the time of our interview, she had been working in the community-based agency setting for 16 years (2). She explained that in addition to working as an in-home therapist, she also taught on an online university and had a private practice (6-8). She was not married at the time of the interview but maintained strong relationships with her young daughter and the other members of her family. In addition to her 16 years of working as an in-home therapist and being recommended by colleagues, she summed up her success in the following way: "I don't think I have ever really come close to burnout. The only thing that I had conflict with was CEOs. Burnout with my job and clients, no I have always enjoyed that" (102). Barbra's methods of avoiding burnout will be discussed more in depth later in this chapter.

Bob

Bob is a 46-year-old MFT with a master's degree in Marriage and Family Therapy. He was single at the time of our interview and does not have children. He had been working for the past 12 years at a community-based agency located in the greater Broward County area. Bob was recommended by his supervisor for this study because of his long history with the company and consistency maintenance of a 40 hour-per-week schedule. Bob expressed his enjoyment of his work by saying, "I enjoy actually, even now, is when I open up a case. Because this is the opportunity that I get to do the whole spiel. I love that".

Tim

Tim is an MFT who was in his early 60s at the time of the interview. He has a master's degrees in Marriage and Family Therapy. He was recommended by both his colleagues and his supervisor for this study. When we met he had been working as a part-time in-home therapist for a number of years. He told me he enjoys working with children, saying, "kids keep me young" (Tim, 12). Describing his work, he said that, "It was fun because your helping and seeing . . . the help that you give to people" (195).

Mona

Mona, an MFT in her late 40s, was working as a full time in-home therapist in a well known community-based agency in the greater Fort Lauderdale area at the time of our interview. She is married and has children. Mona described her enjoyment of doing in-home work by saying, "For me, the payoff is being able to see people have their lives and being able to move on from where ever it is that they, the challenges that they struggle with" (Mona, 13).

May

May is a 45-year-old Peruvian MFT with a master's degree in Marriage and Family Therapy. She is married and has a teenage daughter from a previous marriage. At the time of our interview she was working as the director of a community-based agency. May has worked as a director, supervisor, and in-home co-therapist with some of her colleagues for eight years (May, 52). She elaborated on how she enjoyed her work by stating, "I really enjoy my job because I am passionate to serve most vulnerable population, our children. I am a clinician at first and love working in the home and doing co-therapy with my team. I feel that they have excellent clinical skills so when they need

me, I am there to support them. Furthermore, we work together as a team. This is what I like” (May, 58)!

Amy

Amy is a Costa Rican MFT who was single and in her early 40s at the time of our interview. Apart from doing in-home therapy, she also has her own private practice. She spoke about her tenure in the field by stating, “I am at this for so many years. Actually for most of my life. Most of my professional life”. She expressed her work enjoyment by saying, “I think one of the first things that I think is rewarding for me is maybe the benefits that I draw from by going to the homes.” (Amy, 10). Amy went on to say, “I enjoy the driving very much and going to places, different places. I feel like I am a cab driver” (24). As shown in Table 1, the demographic information for each the participants are summarized.

Results of Thematic Analysis

After completing all participant interviews, I assigned each participant a pseudonym and listened to each of the six audio recordings multiple times to transcribe the data. I then analyzed each of the six transcripts using thematic analysis (Aronson, 1994; Creswell, 2007; Finlay, 2011; Harvard, 2008). I began by first numbering each line of each transcript and then coding the relevant sections of the transcript (Creswell, 2007). The actual coding process involved reading through each of the entire six transcripts and highlighting excerpts that related to the initial research question: What works for successful in-home family therapists working at community based agencies? I identified recurrent words and phrases and developed codes using words from the excerpts.

When I finished the coding process, I looked for patterns among the codes and categorized them into themes (Aronson, 1994; Finlay, 2011; Harvard, 2008). Following this step, I organized the themes and maintained frequent contact with my Chair to gain feedback. The succeeding themes developed through this process are the following:

1. Successful in-home therapists enjoy their freedom of their jobs
2. Successful in-home therapists schedule their time creatively
3. Successful in-home therapists understand their clientele
4. Successful in-home therapists practice self-care
 - a. At work
 - b. In their personal lives
5. Successful in-home therapists vary clientele

Theme Essence

In this section, I will explain each theme using excerpts from all six of the study transcripts (See Appendix D). It should be noted that the excerpt citations reflect the participant's name and line number on transcript.

Theme 1: Successful In-Home Therapists Enjoy the Freedom of Their Jobs

The first theme I formed through the coding process was *Successful in-home therapists enjoy the freedom of their job*. This theme highlights the freedom and flexibility in the context of the driving and scheduling nature of in-home work experienced by therapists. This was expressed by two of the six participants: Tim and Amy.

Tim said:

I'm ADHD and I love the idea of getting up and going somewhere else in an hour or so. And driving to 'em and it's exactly what somebody like me likes to do:

People that keep on the move! (Tim, 6)

He went on to state, "Plus I tried sitting at a desk and I can't do it" (8).

Amy also described her enjoyment for driving by saying: "I enjoy the work. I enjoy going driving" (Amy, 20). She elaborated further by stating, "I enjoy the driving very much and going to places, different places. I feel like I am a cab driver" (24).

In addition to the driving freedom, Amy elaborated on another freedom afforded to her in the field by stating, ". . . there is no constraints in terms of time. I set up my own schedules" (31) with "my own times" (33).

Summarizing the essence of the first theme, *Successful in-home therapists enjoy the freedom of their job*, Tim and Amy reflected on the concept of driving to different places and making their own schedules. As such, they are in charge of their own time and have the ability to "organize their organization" of clients based on their location.

Theme 2: Successful In-Home Therapists Schedule Their Time Creatively

The second theme that emerged from the transcripts was *Successful in-home therapists schedule their time creatively*. This theme describes how in-home therapists have the flexibility to create their own schedules and accommodate them to both aspects of their professional and personal lives. Participants' excerpts reflected that time management and schedule organization are necessary for in-home therapists to function

successfully in their careers. Of the six participants, Barbra, Tim, and Mona's excerpts connected most to this theme.

Referring to how she schedules her time, Barbra stated, "I'd make sure I get out before dark" (Barbra, 26). She went on to say, "I try to see all my patients when my daughter is at school or at one of her sports activities" (50). She said, "You have to be flexible in a way" (52). She explained, "... if I have a no show (62) ... and I call them and they are not on their way home none of that stuff. They don't answer" (64). "Then my next client, I'll call them and say can I come over earlier. Right. Move people around. See who I can see" (66). Barbra clarified that she utilizes creativity in her scheduling of clients and adapts to no-show situations and last minute changes.

Another participant who practiced using creativity in scheduling was Tim. He explained, "I have to call reminders. I have to set up appointments." (Tim, 30). He said, "sometimes for one hour of therapy, I'll drive 2-3 hours. But again, I am fortunate because I don't mind" (52). He explained that "since I am part time, I can schedule an amount to make a circle, I said, I don't mind the drive" (54; 56). Tim utilizes his time to make reminder calls and set up appointments. In the process, he schedules his clients so he can drive in a circle back to his home.

Tim went on to describe his schedule breakdown, which allows him to attend to both professional and personal aspects of his life. He said, "My nights are in the morning (82). He stated, "That's when I relax, have coffee with my wife, watch a little TV" (84). He added, "All that. I don't get ready till afternoon" (86). Describing his scheduling systems, he said, "the kids start getting out at 2. And the parents get home and all that. I have no problem going to a 9:00 meeting at night" (92). With his work time starting at 2

PM and ending at 9 PM, he explained that, “I’ll sleep until 8 or 9 in the morning tomorrow. So it’s no big deal” (100). “You have to turn your head around a little but to an upside down day” (102). Tim acknowledged that he implemented creativity into his daily scheduling routine so he can have an “an upside and down day” while making time for what he personally wants apart from work: quality time with his wife and some time to relax.

Mona is another participant who utilizes creativity in her scheduling. She said, “If somebody is chronically or they call last minute or something like that” (Mona, 33), then I’ll try to remind them more often” (37). Given the chronological order of her scheduled clients, she has to accommodate her time so to she can give her clients reminder calls for their up-coming appointments so as to avoid last minute cancelations. This is in addition to her routine management of her clients’ sessions and completing her paperwork. She described her week by saying, “It’s over 30 hours” (69). “Most of the time, I’m able to do” (75). She explained, “A couple months ago—well, last month, I guess—I was a few hours off and I had a lot of PTO build up” (77). She clarified, “So it’s not really an issue” (79). Using creative scheduling, Mona manages a caseload of 30 clients and is able to successfully maintain it most of the time. As such, she has a lot of PTO built up over time, so even if she is a few hours off, it is not an issue for her. She further described, “For me, the week is kind of scrambled” (505) and said, “Yeah. I am very flexible” (507). Mona summarized that she has had scrambled weeks that required her to be creatively flexible with her appointment scheduling.

The second theme, entitled *Successful in-home therapists schedule their time creatively*, was mostly supported by Barbra, Tim, and Mona. Some of the main elements

of this theme that stood out in the excerpts were adaptations to manage time for both professional and personal responsibilities and being flexible in altering the schedule when needed. This theme represents an essential part of being an in-home therapist.

Theme 3: Successful In-Home Therapists Understand Their Clientele

The third theme surfacing from the transcripts was *Successful in-home therapists understand their clientele*. This theme defines how in-home therapists establish therapeutic rapport with their clients by taking steps to understand who they are working with and what their clients' lives are comprised of. Through this process, in-home therapists can present themselves with an open mindset and interest in learning about their clients' uniqueness and struggling circumstances while adapting to better join with, engage, and connect with them. This section includes several excerpts from four of the six therapists: Barbra, Bob, Mona, and Tim.

Explaining how she adapts to no-show situations with clients, Barbra said:

So the no shows, I'll call them. To see where they are, maybe they are running late. If not, then we will reschedule. And if it's more than 3 no shows then I'll close the case.

(Barbra, 58; 60)

Barbra elaborated that in no-show situations, her procedure is to call clients and attempt to inquire if they might be running late. However, if that is not the case, she reschedules and closes the case after three no-shows. Doing this helps her handle and maintain her professional standing as an in-home therapist while portraying herself as concerned and understanding.

Mona connected with Barbara's interpretation of her clients' no-show occurrences by saying, "I don't see that necessarily as a bad thing" (Mona, 99). When I inquired what she meant by this, she said:

Because then it tells me that they are moving on and they are feeling better about things and they can schedule things as they need. I don't like it obviously, that they miss in mine. But it does send a message. Maybe, they don't really need therapy right now. And their doing okay. And that's when I want to go (101; 103).

Mona indicated that clients' no-show occurrences send an indirect message that she interprets as an attempt to communicate that they are moving on and feeling better. She gathered that perhas it is an indication that they no longer need therapy.

In addition to describing his interpretation of no-shows, Bob elaborated on the importance of therapists building trust in an effort to understand their clients. He said:

With some of my clients, trust is a big one! Number one, they don't want you there! It's hard to do therapy with someone who does not want you there! (Bob, 248; 250)

He then went on to state:

So, what you do, hopefully, first of all you have to gain their trust. And, unfortunately, that takes along time. Even once you gain their trust, that doesn't imply that they are actually going to follow up with their therapeutic goals. But, I think, in between, that time in between they actual have someone that they can talk to and they can trust. Not looking for answers. (252)

Bob considered trust to be an essential factor in the process of conducting in-home therapy. By focusing on this versus looking for answers, therapists present themselves in

a more favorable light to their clients because they portray themselves as being someone the clients can talk to and trust. Once they establish trust, therapists can maintain the focus on the process of therapy instead of the end goal of only focusing on clients' treatment goals.

In addition to building trust, Bob also expanded the importance of in-home therapists being genuine by saying, "It's like over and over again. But I think, genuineness, I think that would be number one" (41). He then said, "Be yourself. And I understand like you can't get positive to get along with everybody" (43). Bob went on to explain:

I try to explain to the clients that if they feel comfortable with me fine. If not, I am not going to get offended. Because if you don't tell them listen, this is a waste of time, your time and my time. Because if you don't have the first step, you set up an appointment, lets say oh Wed. at 2:00 whatever. Every time you go there, they are probably not going to be there. (45; 47)

Later in the interview, Bob stressed that in his experience, when they are being genuine, therapists also come across as being straightforward. He shared:

Actually, luckily enough, I haven't had any, I haven't had any problems in terms of conveying exactly what I say. I tell my client's that I am pretty straightforward.

I would appreciate it if they were straightforward with me too (200; 202).

Highlighting the need to be genuine, Bob stated that in-home therapists should portray themselves as being honest and straightforward with their clients, inquiring whether the clients feel comfortable working with them. According to Bob, therapists have the opportunity to check in with clients in efforts to understand their standards regarding how

they operate and do their job. In the process of being straightforward with clients, Bob aims to relay to his clients his desire for them to reciprocate and be straightforward with him as well. In doing so, he highlights the two-way street open dynamic of the therapeutic relationship existing between in-home therapists and their clients.

Bob recommended that in-home therapists encourage their clients' parents to be part of the entire therapeutic process. He explained:

So I need the adults at the beginning and maybe later on. I think that understanding the whole process, the dynamics, and the whole problem. So let's say the parents were at work. Johnny doesn't listen to me. The Johnny goes, 'Mom, Where's my dinner'. Oh it is on the table honey. Well we, the parents need to figure out, 99.9% of my parents are sending mixed messages. They need to figure out and be consistent. (191; 193)

Insisting on parents being present for their children's therapy, Bob spoke about the importance of using a systemic approach rather than focusing on the individual members of the family. He explained that taking this approach helps him address mixed messages parents send naturally and unconsciously to their children. By including the parents in session, Bob is able to work with family relationship issues that precipitate stress for all family members.

Tim shed light on the mindset in-home therapists should have by using a metaphor:

You know that. If you are taking things personally, you should take up welding or something. (Mutual laugh between Researcher and Tim). You, not a therapist. (313)

Tim pointed out that in-home therapists have to position themselves in their work to not take their clients' issues and resulting actions personally. He explained that when therapists take client material personally, they step over a line demarcation that separates therapy used to address client needs versus therapy that addresses personal needs.

The excerpts from Barbra, Mona, Bob, and Tim underscore the following issues: therapists' interpretation of no shows, the importance of trust building, the need for in-home therapists to be genuine and straightforward, the importance of client's parents being present during in-home therapy sessions, and the need for therapists to avoid taking things personally.

Theme 4: Successful In-Home Therapists Practice Self-Care

The fourth theme, *Successful in-home therapists practice self-care*, describes the self-care methods in-home therapists have available to them in both their professional and personal lives to aid in the alleviation of stress and help them remain successful in their work. This theme is divided into two sub-themes: (a) *At work* and (b) *In their personal lives*.

At work. This sub-theme, *At work*, is further divided into two areas: (1) coworker and supervisor feedback and (2) team meetings. Coworker and supervision feedback was supported by three of the six participants: Barbra, Mona, and May.

Regarding this subject, Barbara stated:

I don't know if it's directly with counseling or with other therapists, if I need someone to talk to like a supervisor or coworker to bounce off clients that are more difficult. (Barbra, 10)

She indicated that having support and feedback from both her supervisor and coworkers in the community-based agency setting helps her manage her stress on the job.

Mona also spoke of her supervision experience as a professional self-care method that she implements in her life. Regarding “. . . the supervision you have every 2 weeks” (Mona, 519), she explained, “If I feel that some this is really bothering me, then I will talk it out in supervision. I can always come in and call my supervisor” (525).

Relating to her utilization of supervision, May said the following:

We meet for supervision once a week. So that hour of supervision that I get with them, I give them time to let me know how they are doing, personally. Because I know that when they have a personal problem that’s definitely going to effect them in their work. (May, 80; 90).

May further elaborated on how she portrays herself as a supervisor to the therapists in her agency by saying:

I think one of my biggest things because I have a great support system is that I want them to have that too. You know, and to have a support system at work, is a huge deal because I am able to recognize that I need it. So I am able to recognize it for them. So well when ever they have a problem, I have an open door policy. Come in. Let’s talk about it and what is going on. Do you need time off? Do you need therapy? (90)

Recognizing her need for a support system, May tries to provide the same level of support to her therapists by having an open door policy and encouraging them to come in and “check in” with her to discuss what is going on. She further stated:

So we have a lot of conversations on what's it like to be in the home, how are the feeling, and what's going on? So when those boundaries come up, a lot of conversations about how they are feeling, about what they can do different, if there is a big problem, I will definitely will have to be involved, go in and see what is going on with the family. And if I feel that it is not a fit for the family, we will definitely transfer the case to another therapist. (82)

She talked about her check-in times as opportunities for therapists to come in to talk openly with her about their feelings and boundary-setting issues in their work.

Two of the six participants, Mona and May, spoke about the need for support among in-home therapists. Mona said that, staff meetings occurred “. . . once a month.” She explained:

We kind of talk to each other and kind of help each other out. And it's not like it's a support group. I don't feel like there is a support system in that ways. (525)

Even though the group meeting facilitates an opportunity to openly talk with peers, Mona did not find it amenable to her need for support.

May, on the other hand, said that she encourages her therapists to discuss boundary issues during their individual supervision appointments with one another. In addition to seeking supervision, she also utilizes team meeting activities to encourage team work and a togetherness mindset. She explained:

We have team meeting twice a month; every 2 weeks. I do ask how they are feeling once a month. What I started doing this year is that I like to know what the goal of this year is. And how they are accomplishing that goal? Because I want them to feel that it's important for them to have a balanced life. (122)

Attempting to promote a balanced life, May encourages her therapists to be mindful of their goals and self-reflect on how much they have accomplished. She elaborated:

I try to do it for all of them; it's not just one. You know it's not. It try to give or provide that environment overall. It's exactly what you said we try as an agency to thrive to provide. Because we want employees' retention. (128)

By promoting employee morale and teamwork, May said she is also boosting employee retention as well.

May explained some of the team activities she would plan as a supervisor by stating:

If there is anything that we do, basically, is because I offer it. You know, I create certain. And what I do a lot with them is create activities like team activities. For example, for usually the holidays we do something big. For all of them. We do it usually 2-3 times a year. But am one example, we did 2 years ago, like a family night. And it was a Miami, Heat family night. Of course! So that was a really nice way of bonding. You know, we all went together. So we do that 2-3 times a year.

Different things of team building.

In May's supervisory role, she creates supportive team-based activities for the agency therapists. She shared with me some examples of activities and events she leads, such as her Miami Heat Family Night, which she planned as a nice bonding activity promoting togetherness and team building.

In their personal lives. This sub-theme is divided into five distinct parts: (1) establishing personal time, (2) breathing, (3) exercising, (4) family, (5) traveling, and (6) spirituality. Each of these areas is supported by interview excerpts centered on

participants' use of personal self-care methods as a means of managing stress and avoiding burnout.

The first part of this sub-theme, *establishing personal time*, was only supported by Barbra. She said, "I don't take it home with me" (Barbra, 104) and "I just leave it at work. Leave it in the car. Wherever my office is" (Barbra, 106). Doing this allows Barbra to maintain her professional boundaries and distinguish between her clients' lives and her personal life.

The second area within this sub-theme is *breathing*. This was supported by Tim only. He said "I don't like to drive in traffic. . . . But I have learned relaxation breathing and it helps" (Tim, 56; 58). Tim highlighted that his method of coping with driving in traffic is engaging in deep breathing.

The next focus, *exercising*, was elaborated on by Bob, Barbra, and May. Bob said:

The other thing I do, I don't know this sounds corny I guess, I have a diet and I exercise a lot. I actually arranged my schedule; the time that the bracket that I have between 2 and 4 or 2 and 6; I arrange that purpose so that I can do what I need to do: exercise-wise! Because, this is my job. You got to make it priority! Lets say that today is my running day, I'll get up in the morning and I'll figure out. All my scheduling is based upon that goal! (Bob, 239; 241)

Bob explained that his personal self-care is centered on his diet and exercise. He talked to me about how he prioritizes his exercise and meals as a means of scheduling his time around his personal needs while still attending to his professional responsibilities.

Barbra mentioned that among other methods of de-stressing, she works out as a way to avoid burnout (Barbra, 103). May also said, “I do a lot of meditation, and I do, yoga or any physical activity” as a means of preventing burnout.

The fourth part of this subtheme, *family support*, is illustrated in excerpts from Barbra, Tim, and May’s interviews. Barbra said:

I try to see all my patients when my daughter is at school or at one of her sports activities. Worst comes to worst, I have family and friends that can help me watch her. (Barbra, 50)

Barbra emphasized that when she is working with clients, she sometimes has to ask her family or friends to babysit her daughter. This requires her to rely on her family and friends for support. She also said:

Once I am off the clock, I go home take care of my daughter, go to her sport’s stuff, movies, whatever workout (Barbra, 104)

Barbra shared that when she is not working, she spends time with her daughter, going to her sports activities and taking her to the movies. She explained that her daughter helps her unwind and have fun after work.

May also relayed that she has her family’s support by stating: “I am able to speak to my supervisor and take the time off. They know . . . the support of my family and doing things for myself helps me” (May, 50). May views her family as being supportive and being there for her when she needs to take a time off from work due to stress building up.

Tim also related that he relies on his family for support. He was the only participant who indicated a strong appreciation for spousal support:

I think that I am lucky to have a wife like I do. I married the nicest person I have ever met. You know. And even to the point where I would be getting work in and going a date earlier. She would make it a point to go out. Somewhere on the patio or something when I am getting ready; she new I had to remember to get this and get that and get everything together. And she didn't want to have a conversation until I was ready to go. (Tim, 245; 249; 251; 253)

Tim explained:

And she understands that I don't want to come back for my phone or something like that. She will fix dinner anytime in the day or night. She is just a terrific person. Good person. Smarter than I am, too. No, She is the first in command! (255; 257; 259; 265)

He added:

She'll go, "When do you think you'll be home" and "Are you ready for this"? Oh and are you ready for this, when I come home at 8:00 or 9:00, she'll wait to eat dinner with me. (276)

In this portion of the interview, Tim described how his wife helps him avoid burnout: by being there, helping, and understanding him. Tim explained that he relies on his wife's help and described her as being the first in command; she helps him cope with his stress and relax.

The next area that supports this sub-theme is *travel*. It was elaborated on by Mona and Amy. Mona said:

Yeah, I tend to take a lot of different times, you know, take weekends and go away to different places. I mean, you know, go on cruises. We go to visit

family. (Mona, 410)

Mona explained that she travels and visits her family. Amy also described traveling as a form of self-care and stated that she does it as often as possible as a means of avoiding burnout. She said:

I am very aware when I am in that process, when I am saturated, as like to call it. So what is it that I try to do is to retreat myself where I literally remove myself, take a vacation, and take time out. Do anything, reduce my hours, anything to prevent. Have good sense of humor. (Amy, 353; 355)

Amy described her method of self-care as taking time out to go on a vacation. She further explained:

I also take frequent vacations. I have a house, a little house actually in the mountain, Costa Rica. . . . So my house is right there on the peak of the mountain. So when I go there, I go sleep for the first two days. And I just deep breathe. And then I like touching the earth, because then I know I am in my country. In Costa Rica there are a lot of volcanoes. So the land is very different. The land has a lot of minerals and colors because of the volcanoes. So when you touch it and you smell it, you know this is a different feeling. So that's like you revive yourself. It's like you contain yourself just a little, and then you go over there and you let loose! (364; 366; 386; 370; 374; 377; 379; 383)

Amy shared that since there are a lot of volcanoes in Costa Rica and the land is different from anywhere else she has been, she indulges in the smell of the soil and how it feels. This allows her to let loose and relax.

The last part of this sub-theme is *spirituality*. Of the six participants, two related closely to it: May and Amy. With regard to her spiritual practice, May said:

I need to have my time to, you know, to disconnect and to kind of like reflect on what is going on, process my feelings, how I feel towards her. For me, I am very much, very spiritual. So I do a lot of praying, and I do a lot of meditation. And if there is something that affects me tremendously, definitely I would have to go and talk to a therapist. Even for me, for all of us. (102; 103; 105)

May described her primary method of self-care as disconnecting and allowing herself to reflect and process her feelings. Acknowledging that she is a spiritual person, May said she utilizes prayer, meditation sessions, yoga, and physical activities to help her re-center. She said that if there is something affecting her tremendously, she sees her therapist.

Amy also commented on being spirituality connected by saying:

I am very positive and I also have faith. And so it is my faith. My faith in God. That is my rock! And so am I based everything that I am and that I have I owe it to God so I live my life gratefully. I am very grateful for what I have. So I think that I noticed that the people who have faith, anything, religion, higher being, whatever. That connection with a higher being. (357; 359; 361; 363)

May explained how her faith has guided her and helped her to be grateful. Her faith in God allows her to connect to a higher being and channel herself and her mind. In addition to having her spiritual connection, she also stated:

. . . but I think I just keep going back to my center: who I am and my mission in the world and my purpose in being here. So that's why I stay and I think this is why I stay sane. (383; 385)

Amy elaborated that by being a woman of faith, she is able to go back to her center and remember who she is and what her purpose is for being here. Doing this helps her function and stay sane in her work.

Theme 5: Successful In-Home Therapists Vary Clientele

The fifth theme, *Successful in-home therapists vary clientele*, is derived from participants' reports of how varying clientele is a means of avoiding burnout among in-home therapists. Of the six participants, two provided information related to this theme: Barbra and Mona. Barbara explained that "switching different areas" is one way of her means of avoiding burnout. She stated:

I worked with children for many years. But then switching the areas with the children. Not just focusing on ADHD. Then I got my specialty in Reactive. RAD: Reactive Attachment Disorder. Studying different things moving around and then you know, the last 3 years I have been working with elderly a patient which is totally different. So I avoid. (88; 90; 92)

Adding to what Barbra said, Mona expanded on the importance of varying clientele by saying:

I don't see them every week. You know, some I see them every other week or once a month; a few every week. There is a lot of different variations. Yeah that is it. I have my calendar. I have my week going. So you just need to keep track of it. (Mona, 442; 446; 448)

Barbra spoke about how she varies her clients and explained that since she has a lot of experience working with children diagnosed with ADHD, she is able to focus on other aspects of the case. Eventually, she got specialized and studied different things. She switched her client focus from children to elderly patients so as to avoid burnout.

Mona, on the other hand, varies her clients by seeing some clients every week and others every other week. She stressed that varying the frequency with which she meets with clients she is able to manage her calendar and gauge her clients' therapeutic flow.

Summary

The themes I generated through the transcribing, coding, and data analysis processes were supported by excerpts from my interviews with the six therapists who participated in this study. As seen in Table 2, each of the five themes and the participants that supported them can be viewed.

The six successful in-home family therapists who participated in the study are able to do their jobs at community-based agencies mainly by enjoying the freedom of their jobs, scheduling their time creatively, understanding their clientele, having self-care both in their work and personal life settings, and varying their clientele.

CHAPTER V: DISCUSSION AND IMPLICATIONS

As noted in Chapter IV, I derived five primary themes from my analysis of the interview data: (1) Successful in-home therapists enjoy the freedom of their jobs; (2) Successful in-home therapists schedule their time creatively; (3) Successful in-home therapists understand the unique needs of their clientele; (4) Successful in-home therapists practice self-care; and (5) Successful in-home therapists vary their clientele. These themes represent the means by which the participants remain successful in their work as in-home therapists.

The first four themes connect with aspects of the existing literature on resiliency (Appel & Appel, 2008; Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff & Binstock, 2001; Corey et al., 1998; Edward & Patterson, 2006; Fontes et al., 1998; Grosch & Olsen, 1994; Guise, 2009; Hamel & Laraway, 2004; Killian, 2008; Leiter et al., 2001; McCollum & Gehart, 2010; Negash & Sahin, 2011; Paris et al., 2006; Rosenburg & Pace, 2006; Stinchfield, 2004; Richards et al., 2010; Skovholt & Trotter-Mathison, 2011; Thomas, 1999; Tosone et al., 2012; Walter & Petr, 2006). The fifth theme appears to be a new addition to the literature.

Connections to the Existing Literature

Themes One and Two

The first two themes—(1) Successful in-home family therapists enjoy the freedom of their jobs, and (2) Successful in-home family therapists schedule their time creatively—highlight the need for flexibility and adaptation among in-home therapists. Appel and Appel (2008) explain that professional stress spills over into the personal domain, often contributing to an increased overall level of distress among therapists.

Keloway and Day (2005) elaborate on this point by narrowing the common sources of work stress into six categories: (1) workload and pace, (2) role stressors, (3) career concerns, (4) work scheduling, (5) interpersonal relationships, and (6) job content and control. When therapists experience these stress factors, they find themselves in a constant bind due to the lack of balance existing between their personal and professional lives (Grosch & Olsen, 1994; Maslach, 1982).

The findings of this study suggest that to cope with the combination of these factors and the stress associated with working at community-based agencies, in-home therapists become resilient by enjoying their job freedom and scheduling their time creatively. By doing this, they are able to prioritize their roles within their families, agencies, and social systems. As the existing literature suggests, therapists who can successfully juggle their work, family, and social responsibilities can more smoothly transition between work and home (Appel & Appel, 2008; Paris et al., 2006).

Theme Three

The third theme—Successful in-home therapists understand the unique needs of their clientele—is related to how therapists present themselves to their in-home clients in the process of building rapport with them. This theme contains five subthemes: (1) therapists' interpretation of no shows, (2) trust building, (3) being genuine and straightforward, (4) insisting that clients' parents be present, and (5) not taking things personally. Each of these elements work together to help in-home therapists establish rapport with their clients.

The third theme also connects with the literature on therapist resiliency, which elaborates on the need for therapists to be flexible and adaptable in understanding the

unique needs of their clients (Boyd-Franklin & Bry, 2000; Christensen, 1995; Clark, 2009; Cluff & Binstock, 2001; Grosch & Olsen, 1994; Hamel & Laraway, 2004; Killian, 2008; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Stinchfield, 2004; Thomas, 1999; Walter & Petr, 2006). Aponte (1985) highlights the importance of rapport building by describing therapy as a personal relationship framed by professional parameters. He elaborates that through utilization of culture, values, and morals, therapists are able to join with, relate to, and understand their clients (Aponte, 1985; Aponte & Carlsen, 2009).

Through therapeutic interplays between therapists and clients, mutual learning and trust are established (Aponte & Carlsen, 2009; Boyd-Franklin & Bry, 2000; Protinsky & Coward, 2001). Once trust is established in the home, therapists have the opportunity to interact with everyone involved in their clients' families, including both blood relatives and non-blood relatives (Boyd-Franklin & Bry, 2000). This allows therapists to generate a big-picture perspective of clients' family dynamics in relation to aspects of their living circumstances—such as poverty, substandard housing, drugs, crime, overcrowding, and unsafe neighborhood—cultural characteristics—including food and music—and family rules in practice (Boyd-Franklin & Bry, 2000). This theme fits with the literature that emphasizes the need for therapists to understand the unique need of the clientele.

Theme Four

The fourth theme—Successful in-home therapists practice self-care—contains two sub-themes: (1) At work, and (2) In their personal lives. The two areas participants elaborated on within the first sub-theme are (a) concentrating on coworker and supervision support, as explained by Barbra, Mona, and May, and (b) team meetings,

which was elaborated on by Mona and May. The second sub-theme contains six distinct parts: (a) establishing personal time, (b) deep breathing, (c) exercising, (d) family, (e) traveling, and (f) spirituality. Each of these areas was supported by participants' excerpts

The areas within the second sub-theme center therapists' self-care strategies used to manage stress and avoid burnout. The importance of self-care is supported in the literature (Corey et al., 1998; Edward & Patterson, 2006; Fontes et al., 1998; Guise, 2009; Hamel & Laraway, 2004; Killian, 2008; Leiter et al., 2001; McCollum & Gehart, 2010; Negash & Sahin, 2011; Paris et al., 2006; Richards et al., 2010; Skovholt & Trotter-Mathison, 2011; Tosone et al., 2012). Self-care consists of physical, psychological, spiritual, and support components (Negash & Sahin, 2011; Richards et al., 2010). Two participants described using physical self-care methods, one participant identified psychological self-care methods, and two participants talked about using spiritual self-care practices. All six participants in this study incorporate supportive self-care practices in their personal and professional lives.

The physical elements of self-care include activities such as exercise, sports, household activities, and daily functioning (Negash & Sahin, 2011; Richards et al., 2010). Psychological self-care involves therapists getting personal counseling to better manage stressful circumstances that could impair their work performance (Leiter et al., 2001; Negash & Sahin, 2011; Paris et al., 2006; Richards et al., 2010; Skovholt & Trotter-Mathison, 2011). In addition to this, spiritual self-care is something that is loosely defined as being geared toward describing the purpose and meaning of life and the connection it makes toward gaining understanding (McCollum & Gehart, 2010; Negash & Sahin, 2011; Richards et al., 2010). Finally, the participants in this study identified

formal means of self-care—such as supervision, case staffing, and peer review—that help them work through their frustrations and struggles with clients, as well as more informal self-care methods—like spending time laughing and having fun with friends—which can help reduce stress and prevent burnout (Guise, 2009; Killian, 2008; Negash & Sahin, 2011; Paris et al., 2006; Tosone et al., 2012).

Theme Five

Within the fifth theme, the participants described how varying their clientele keeps them from burning out. They spoke about different methods of doing this, such as re-focusing on a different population or different aspects of each case. Getting more specialized, being open to learning, and changing the frequency of clients' sessions are all ways in which the participants vary their clientele and avoid burnout. This is a new finding that is not found in the existing literature.

Limitations of the Study

The limitations of this study include the small sample size, which is not representative of all agency types and racial groups. Inclusion of a broader geographical distribution of agencies would have allowed more lived experiences to be gathered and other themes to emerge. In addition to this, there was a lack of racial representation among the participants, given that all six therapists who took part in the study identify as Hispanic or Anglo-American. The findings might have reflected more lived experiences, and more themes would have been derived, if there were a more diverse representation of ethnicities among the participants.

I might have generated more themes if I had scheduled the interviews with participants after the work day, in order to relieve them of the pressure of being

interviewed between sessions. Also, my own bias might have prevented me from seeing some of the positive aspects of what worked for the community-based family therapists in this study. Both of these issues might have had a cumulative effect on my ability to attain a deeper level of understanding of collected data.

Researcher Bias

I attempted to manage my bias by remaining curious throughout the process of interviewing the participants, preparing the transcriptions, and analyzing the data. In Chapter I I explained how I utilize my curiosities to help me work through the professional and personal insecurities I experienced as an international student working on my optional practical training (OPT). This curiosity allowed me to be more open to my coworkers and hear their stories.

Applying the same curiosity when conducting this study allowed me to identify themes that might not have been as apparent if my approach had been more geared toward finding specific, predetermined themes. In addition to this, I checked in with my Chair numerous times to evaluate the results and determine that they are valid from the point of view of the participants. I also received feedback from the participants about the themes I derived.

Implications for Future Research

In this study I utilized a phenomenological qualitative research design to gather the specific lived experiences of successful in-home therapists working in community-based agencies. Even though the results of this study effectively answered my research question, I believe more research should be conducted to investigate in-home therapists' experiences at community-based agencies. Future researchers on the topic should include

mental health counselors and social workers in their samples. Given the differences in formal training among professionals in the different mental health professions, researchers might qualitatively explore topics such as how successful in-home therapists balance their work lives and their home lives, how therapeutic change is derived and interpreted by therapists, and how in-home therapists practice and maintain their self-care practices.

Another direction future qualitative researchers can venture into is an exploration of the successful experiences of on-site, community-based therapists. Researchers can either select a general population that includes marriage and family therapists, mental health counselors, and social workers, or they can choose to focus on a more specific population of in-home therapists. By utilizing a general population design, future researchers can study how success is interpreted differently among therapists in the fields of marriage and family therapy, mental health counseling, and social work. Such research would provide information about how different helping professionals balance the professional and personal aspects of their lives. It could also address how therapists make sense of and maintain professional passion and self-care.

Quantitative research studies on this population would also contribute to the existing literature on this subject. Future studies could include a general comparison of the number of marriage and family therapists, mental health counselors, and social workers who utilize specific self-care methods, such as meditation and taking breaks. In addition, researchers can design a comparative longitudinal study with a set number of community-based agencies located in the greater Fort Lauderdale area, exploring successful therapists' utilization of self-care techniques to balance their professional and

personal lives. The data from these quantitative studies can be used to develop self-care training programs for community-based agencies to support the in-home therapists who work in them.

Implications for Training

The results of this study can be used to create a beneficial training program that promotes resiliency among in-home therapists in community-based agencies (Aponte, 1991; Aponte & Carlsen, 2009; Aponte & Winter, 2000; Clark, 2009; Hamel & Laraway, 2004; Kuiper, 2012; Protinsky & Coward, 2001; Rosenberg & Pace, 2006; Wolgast & Coady, 1997). To achieve this, I plan to incorporate each of these five themes to develop the five core concepts of this training program: (1) enjoy the freedom of in-home therapist jobs within community-based agencies; (2) implement time management and flexible scheduling skills; (3) understand the unique needs of a community-based agency's in-home clientele; (4) implement professional and personal self-care practices; and (5) vary clientele. I will explain each of these core concepts in my training program to teach family therapists how they can adapt to promote better balance in their personal and professional lives while avoiding burnout and maintaining their careers as in-home therapists in community-based agencies.

I plan to develop two versions of the training program, designed for two specific settings: (1) community based agencies, and (2) master's level classes at universities. For community-based agencies, I plan to relay the core topics in a condensed format. Since employed in-home family therapists will have accumulated professional experiences, the introductory portion of the training will include a discussion of how in-home therapists become stressed out and burned out due to a combination of their professional and

personal responsibilities. After establishing this foundation, I will present the findings from this study, share the process by which I developed the five core concepts, and explain each of them so they can be understood in the context of in-home community-based work. Following this, I will offer opportunities for therapists to participate in role-play exercises and describe how the participants could implement the core concepts from the training in their professional lives. The training would be aimed at helping participants become more resilient in-home, community-based therapists, finding a balance between their professional and personal responsibilities.

In the master's level course version of this program, I plan to teach each of the core concepts to graduate family therapists. I will briefly discuss how in-home therapists in community-based agencies function, what is required of them, and what the chances are for them to become stressed out. Once participants understand the context of in-home, community-based agency work, I will present the topic of resiliency and discuss how it helps in-home therapists develop a resilient attitude and sustain optimal functioning. In order to help student family therapists further understand in-home, community-based agency work, I will assign readings from published articles and textbooks pertaining to each of the topics covered in the training. Open-ended discussions of the readings will allow students better understand the course material. This training course will include mandatory role-play exercises designed to allow the students to experience the roles of both client and therapist. I will personally pick students to do this in order to emphasize the spontaneous, unplanned nature of in-home, community-based work. Students of this training course will have to prepare a final paper that will give them an opportunity to share their opinions about how in-home, community-based therapists can develop and

practice resiliency. Students' grades will be determined by their participation in class discussions, engagement in role-play opportunities, and performance on the final paper.

In the process of delivering this training in both community-based agencies and graduate programs, I will present the material from the themes of this study to support the work of in-home family therapists and prepare family therapy students to enter the field. In addition to learning how to become resilient therapists, participants in the training programs will learn to use the core concepts as a means of reducing their stress and increasing their overall management of personal and professional responsibilities.

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Table 1

Participant Demographic Summary

| Participant Name | Gender | Ethnicity | Country of Origin | Marital Status |
|-------------------------|---------------|------------------|--------------------------|-----------------------|
| Barbra | Female | Irish | U.S.A | Single |
| Bob | Male | Anglo-American | U.S.A | Single |
| Tim | Male | Irish | U.S.A | Married |
| | | Anglo-American | | |
| Mona | Female | American | U.S.A | Married |
| May | Female | Hispanic | Peru | Married |
| Amy | Female | Hispanic | Costa Rica | Single |

Table 2

Themes Indicated By Participants

| Themes | Barbra | Bob | Tim | Mona | May | Amy |
|--|---------------|------------|------------|-------------|------------|------------|
| 1) Successful in-home therapists enjoy the freedom of their jobs | | | X | X | X | X |
| 2) Successful in-home therapists schedule their time creatively | X | | X | X | | |
| 3) Successful in-home therapists understand their clientele | X | X | X | X | | |
| 4) Successful in-home therapists practice self-care | | | | | | |
| a) At work | | | | | | |
| With coworkers and supervisors who give positive feedback | X | | | X | X | |
| Through useful team meetings | | | | X | X | |
| b) In their personal lives | | | | | | |
| Establishing personal time | X | | | | | |
| Deep breathing | | | X | | | |
| Exercising | X | X | | | X | |
| Family | X | | X | | X | |
| Traveling | | | | X | | X |
| Spirituality | | | | | X | X |
| 5) Successful in-home therapists vary clientele | X | | | X | | |

Appendix A

Introductory Packet

Introduction Letter

Hello!

Thank you for taking the time to participate in my study entitled “Promoting Therapist Resiliency in Community-based Agencies.” The purpose of this study is to explore how successful in-home family therapists maintain their employment at community based agencies and avoid burnout. The study procedure involves researcher scheduling and conducting a one hour interview with participants at a neutral location such as a local library study room. To capture verbal communication, the interview will be recorded using an audio recorder. These recordings will be collected and analyzed for the purposes of this study.

The advantages in participating in this study are that you will be able to engage in an open discussion on the topic of resiliency while feeling empowered and validated about sharing your opinions and perspectives. The disadvantages of this study, is that in the process, old feelings about past events may conjure up old feelings to resurface causing you to feel anxious, depressed, and or fidgety. However, the advantages and disadvantages of doing this study will vary from person to person.

Attached you will find the Confidentiality Packet, Side Effect Handout, and Consent Form. Please review them and contact me if you have any further question. I can be reached at (954) 232-0560.

I look forward to working with you! Take care!

Sincerely,

Aleyah Yasin, M.S.

Confidentiality Packet

Consent Form for Participation in the Research Study Entitled

“Promoting Therapist Resiliency in Community-based Agencies”

Funding Source: None

IRB protocol #:

Principal investigator:

Aleyah Yasin, M.S.

711 NW 101 Terrace

Plantation, FL. 33324

(954) 232-0560

For questions/concerns about your research rights, contact:

Human Research Oversight Board (Institutional Review Board or IRB)

Nova Southeastern University

(954) 262-5369/Toll Free: 866-499-0790

IRB@nsu.nova.edu

What is the study about?

The aim of this study is to explore how successful in-home family therapists maintain their employment at community based agencies and avoid burnout.

Why are you asking me?

For the purposes of this study, a convenient sampling of six therapist participants are needed. To be considered for this study, participants must have a master's degree and more than two years of experience working in a community-based agency. Their experience should be driven from working as a family therapist in outpatient or on-site programs. Therapist participants need to be willing to talk about their experiences while being recorded so that they can provide diverse, rich, and unique stories related to the topic of resiliency (2003).

What will I be doing if I agree to be in the study?

Participant therapists will be partaking in a one hour interview with the researcher at a neutral location such as a local library study room based on participants' preference. The interview will be audio recorded so as to capture verbal communications of therapist and participants.

Is there any audio or video recording?

This research project will include audio recording to capture each of the therapist participant's verbal communications during the one hour interview.

What are the dangers to me?

The procedures of this study can cause participants to remember how they felt during their time working at community based agency settings. As such, they might feel anxious,

depressed, stressed, and fidgety to reconnect with their feelings of burnout remembering other events (personal and professional) that impacted their lives simultaneously. Also, you may experience trouble sleeping and or eating.

However, if you have any questions about the research, your research rights, or have a research-related injury, please contact Aleyah Yasin. You may also contact the IRB at the numbers indicated above with questions as to your research rights.

Are there any benefits for taking part in this research study?

The benefits for taking part in this study is to engage on an open discussion in which participant can freely and openly express thoughts regarding resiliency. In doing so, he or she will be contributing to a general co-construction of the meaning of resiliency and sharing their opinions in the process. Participants will feel empowered and validated in the process of sharing aspects of their lives in the process.

Will I get paid for being in the study? Will it cost me anything?

There is no cost to participants partaking in study. Participants will not be paid financially. However, participants will each be receiving a snack bag from researcher in appreciation for making time to partake in her research study. Snack bags will comprise of candy and a hand written thank you card.

How will you keep my information private?

For confidentiality purposes, the audio recordings collected on researcher's recorder will be available to be heard by the researcher, the IRB, dissertation chair, and committee members. Because your voice will be potentially identifiable by anyone who hears and sees the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the tape as described in this

paragraph.

The recording will be transcribed and analyzed by researcher. The recordings will be kept securely on researchers' recorder camera for a time period of 12 month so as to properly extract data. After such time, recording will be deleted.

What if I do not want to participate or I want to leave the study?

You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Voluntary Consent by Participant:

By signing below, you indicate that

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled
"Promoting Therapist Resiliency in Community-based Agencies"

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Authorized Representative: _____ Date: _____

Authority of Representative is based on: _____

Signature of Person Obtaining Consent: _____

Date: _____

***Please note that if the study does not include individuals who are being represented by an authorized individual then the lines in red may be eliminated—leaving only the Participant's Signature line and Date and the Witness's Signature line and Date.

Side Effects Handout

Study participants may experience:

- Anxiety
- Depression
- Fidgety feelings
- Remembering past professional and personal events
- Trouble sleeping
- Decreased appetite
- Increased appetite

Recommended options to decrease side effects

- Seek treatment from medical physician if experiencing physical pains
- Seek psychotherapeutic services
- Attempt meditating
- Engage in physical exercise
- Center oneself through yoga
- Practice good nutrition

Consent Form

I, _____, have read and understand the confidentiality agreement pertaining to this study and I wish to participate in this research study.

Signature: _____

Date: _____

Time availability

What days are good? _____

Scheduled date: _____

Time: _____

Location

Other locations options: _____

Appendix B**Three-Column Contact Sheet****Three-Column Contact Sheet**

| <u>Name</u> | <u>Telephone</u> | <u>Email</u> |
|-------------|------------------|--------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

Appendix C

Research Advertisement

Hello!

Thank you for taking the time to view my advertisement. I am looking for six participants for my study entitled “Promoting Therapist Resiliency in Community- Based Agencies”. The purpose of this study is to explore how successful in-home family therapists maintain their employment at community based agencies and avoid burnout. The study procedure involves the researcher scheduling and conducting a one hour interview with participants at a neutral location such as a local library study room.

To be considered, participants must have a) a master's degree in marriage and family therapy, b) one or more years working at community-based agencies as an in-home therapist, c) current employment at a community based agency with successful performance, and d) willingness to provide a diverse, rich, and unique self report description of their successful experiences. In addition to this, participants must agree to the researcher using a recording device to gather audio content during each of these interview sessions. Varying from person to person, advantages include being able to openly engage in discussions on the topic of resiliency while feeling empowered and validated about sharing opinions and perspectives whereas the disadvantages include the conjuring of old feelings of anxiousness and depression resurfacing during or after the interview session.

If you are interested in participating and wish to learn more about my study, please feel free to contact me at (954) 232-0560. I look forward to working with you!

Take care!

Sincerely,
Aleyah Yasin, M.S.